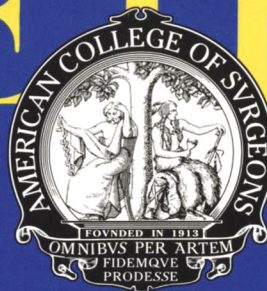
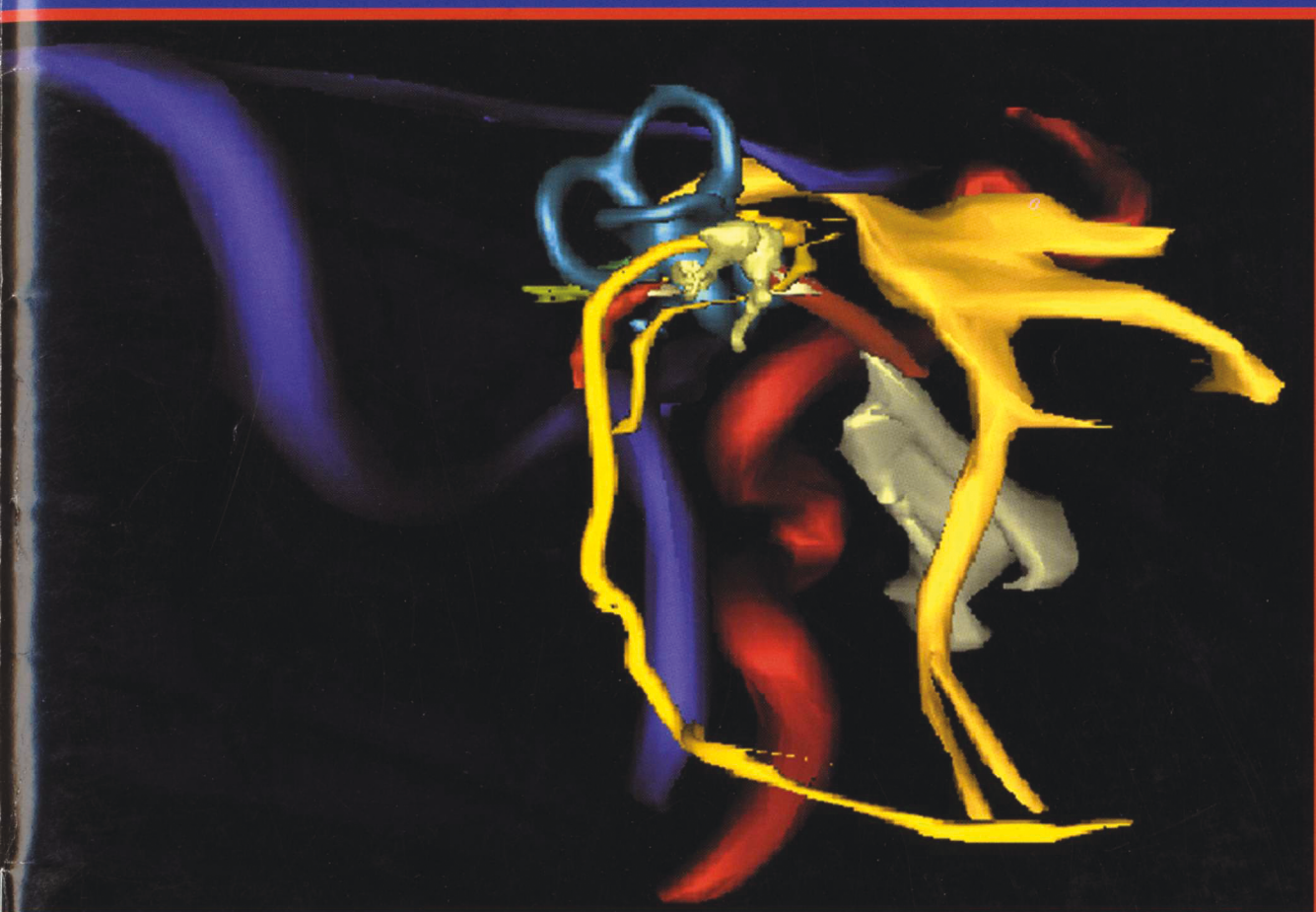


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



March 2001  
Volume 86, Number 3



**VIRTUAL REALITY SURGERY:  
Has the future arrived?**



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## About the cover...

Virtual reality is contributing to safer operations and is making it possible for surgical residents to better study complex parts of the anatomy, according to Karen Sanderick, author of the CyberSurgeon column "Virtual reality surgery: Has the future arrived?" (p. 42). For example, through virtual reality, surgeons and residents can more clearly view the dimensions of the temporal bone as depicted on this month's cover. Details about the image are offered on page 43.



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# From my perspective

**T**he residency review committee (RRC) for dermatology is seeking to establish a subspecialty in dermatological surgery. As a first step toward instituting the new subspecialty, the RRC for dermatology has submitted proposed training program requirements to the Accreditation Council for Graduate Medical Education (ACGME). The proposal calls for creating a 12-month fellowship program in dermatological surgery. Individuals who complete this program would then be eligible for board approval.

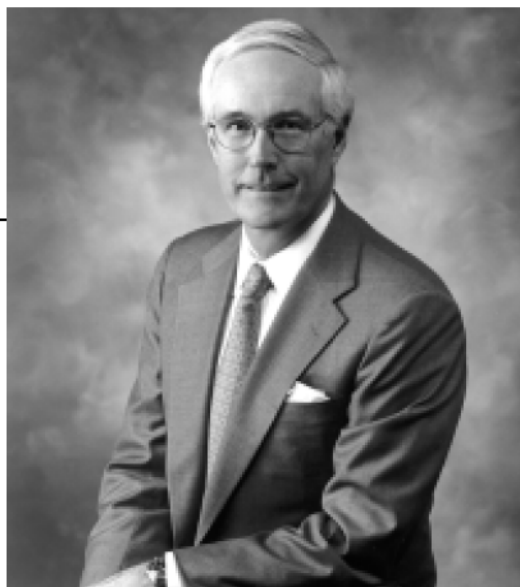
The College has significant concerns about the proposed dermatologic program requirements, and we expressed our views in a December 1, 2000, letter to the ACGME.

## *Flaws in the proposal*

Dermatologists traditionally have performed minor operations and Mohs' micrographic procedures. The training program proposed by the RRC for dermatology, however, would allow their programs to go further and create "surgeons," who could perform a much broader range of operations including hair replacement, tumescent liposuction, soft tissue augmentation, fat transplantation, wound closure techniques, grafts, and flaps. The emphasis would be on teaching dermatologists the surgical techniques involved in these procedures. Little consideration would be given to the analytic skills surgeons need to determine whether the procedures should be performed or how to manage patients postoperatively.

The ACS Advisory Councils for the Surgical Specialties, during their recent meetings, universally agreed that such a wide range of surgical procedures could not be adequately taught in a 12-month period. With a very constructive attitude and without specialty conflicts, the advisory councils determined that the plan was untenable.

Additionally, much of what is proposed in the dermatological fellowship program would focus on outpatient surgery; therefore, peer review processes would not be applied. The ongoing review of the results of inpatient operations allows sur-



**“How much and what sort of training should physicians have if they are to be called surgeons?”**

geons to evaluate quality of care and patient safety and, hence, contributes greatly to the residents' ability to learn and improve.

## *Appropriate training for surgery*

This issue raises a very fundamental question: How much and what sort of training should physicians have if they are to be called surgeons? The College considers physicians to be surgical specialists when they hold valid certification from a surgical specialty board approved by the American Board of Medical Specialties. There are currently 10 of these boards, which, through the individual RRCs, lay out the specifics of their respective training programs—all of which last at least four years. Incorporated into these approved programs are a number of educational areas that take years to cover and that the College believes are necessary components of surgical training. These subjects include basic science, anatomy, anesthesia, ethics, surgical techniques, wound healing, the diagnosis and management of shock, pathology, pharmacol-



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ogy, oncology, epidemiology, legal and regulatory issues, quality assurance, ongoing self-assessment, and others.

Thus, we maintain that surgeons are not just technicians who possess the skills to do operative procedures, but professionals who have a panoply of abilities that allow them to employ surgical strategies properly and safely and who are involved in the entire spectrum of the surgical patient's care. Before one can be considered a surgical specialist, he or she must have a solid understanding of a wide variety of educational and technical areas.

Further, much of what is taught during surgical resident training culminates in cultivating the ultimate criteria used to evaluate surgeons—their use of judgment. The College has strongly adhered to the concept that appropriately constructed training programs endow surgeons with the skills they need to select patients who will benefit from surgery, to have an appreciation of disease processes, and to manage potential postoperative complications. Developing these faculties takes a significant amount of time and exposure to many patients in different settings.

Ours is now a highly scrutinized profession; hence, more than ever there is a need for comprehensive training programs that will prepare graduates for the complexities of practice. These programs cannot be amended and adapted to one-year courses that have technique as the major focus. We must be certain that graduates of surgical training programs have the necessary capabilities, so they can continue to garner public trust.

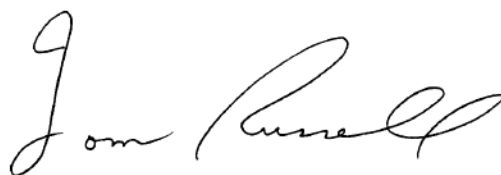
### ***An issue worth fighting for***

The American College of Surgeons has taken a strong position by discouraging the ACGME from approving the proposed one-year dermatological surgical fellowship, asserting that it lacks the comprehensiveness of the other surgical training programs. It does not, in our view, meet the criteria for producing surgical specialists.

Clearly, some surgical techniques can be learned in one year, but the evaluation and treatment of

patients cannot. Granted, some aspects of training could be shortened, and although we may debate what should be included in residency programs, we all surely agree that it goes beyond technique. It would be ill-advised for the ACGME to disregard the basic principles of training and allow this proposal to pass. We await the ruling of the ACGME on this topic and remain firm in our commitment to surgical training that involves a comprehensive disease-oriented, patient-focused approach.

As the forces of change hover over our profession, your comments on this topic would be appreciated.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).



# FYI: *STAT*

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*This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.*



A newly appointed **Health Policy Steering Committee** held its first meeting in Washington, DC, on February 19. Established by the College's Board of Regents, the committee will identify public policy issues and concerns affecting surgeons and their patients and coordinate ACS activities related to those issues. Fellows appointed to the committee represent a broad spectrum of surgical specialties and practice settings.



A new pilot program providing a **Webcast of five scientific sessions from the 2000 Clinical Congress** is now available through the College's Web site at <http://www.facs.org>. Approximately 12 total hours of lectures are available on the following subjects: critical pathways; pain control in the ICU; evaluating operative and perioperative risks in the elderly; medical errors: improving patient safety; and minimizing operating room catastrophes.



At their February 9-10, 2001 meeting, the Board of Regents approved the development and implementation of a **CME Joint Sponsorship Program** within the College's Office of Continuing Medical Education. The program is intended to: enhance relationships with regional surgical societies by providing a cost-effective mechanism for those organizations to grant CME credit to their members; to provide a mechanism for such educational collaboration; and to extend the scope of College-sponsored CME activities through relationships created with joint sponsorship affiliates.



A **Statement on Diversity** was presented to the Board of Regents by the Committee on Chapter Activities of the Board of Governors and was approved by the Regents on February 9, 2001. The statement will be published in an upcoming issue of the *Bulletin*.



The establishment of a Regental **Committee on Minority Issues** was proposed to the Board of Regents by the Board of Governors Committee on Chapter Activities and was approved by the Board on February 9, 2001. The committee will study educational, professional, and health-related issues of underrepresented minority surgeons and patients, and will seek relevancy and support by the College through its mission, policies, and programs.

# Dateline|Washington

*prepared by the Washington Office, Health Policy and Advocacy Department*

## **Patients' Bill of Rights continues to rank high on policy agenda**

On February 7, the College sent a letter to President Bush urging him to ensure that a strong Patients' Bill of Rights is enacted to create a truly level playing field with respect to liability exposure for physicians and health plans. This is the same message that the College expressed in a letter sent to key senators and representatives last year.

The College continues to urge the adoption of a comprehensive Patients' Bill of Rights that includes an independent external appeals mechanism, access to specialty care, and a ban on "gag clauses." In addition, the College supports patients' right to sue their health plan if they are harmed by its medical determinations. As a compromise to this controversial provision, some members of Congress have proposed capping noneconomic and/or punitive damages in the case of malpractice suits brought against health plans. In its letter to the President, the College argued that it would be unfair to enact a Patients' Bill of Rights that caps damages for lawsuits brought against health plans without also capping damages for suits brought against physicians.

On a related note, Senators John McCain (R-AZ) and Edward Kennedy (D-MA) announced their plans to introduce managed care reform legislation that will include most of the protections proposed in legislation that the House passed (and the College endorsed) in the last session of Congress. This new legislation is also expected to have the support of Rep. Greg Ganske, MD, FACS (R-IA). One important difference is that this year's legislation would cap punitive damages against health plans at \$5 million. President Bush has indicated that he would like to see Congress pass strong tort reforms as part of any Patients' Bill of Rights.

## **HCFA announces new Medicare survey**

On February 2, the Health Care Financing Administration (HCFA) announced its plans to conduct a survey of 9,000 practitioners and providers to determine what these individuals and organizations need to know about accurate Medicare claims submission and what they believe would be the best methods for obtaining that information. The draft survey is open to public comment and is currently under review by the Office of Management and Budget as required by the Paperwork Reduction Act.

The survey is one aspect of a Provider Education Project being conducted by the Medicare program. Medicare officials say they will use the results of the survey to create an education program that will help physicians and others "submit Medicare claims that get paid quickly and accurately the first time." More information about the proposed survey can be found at [www.hcfa.gov/regs/prdact95.htm](http://www.hcfa.gov/regs/prdact95.htm); comments on the draft are due by April 3, 2001.

## **OIG releases reports on EMTALA**

On January 22, the Department of Health and Human Services' Office of Inspector General (OIG) released two reports regarding the Emergency Medical Treatment and Labor Act (EMTALA). The first report, *Survey of Hospital Emergency Departments*, describes the results of a mail and telephone survey of emergency depart-



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## **HCFA announces change in anesthesia supervision rules**

ment managers, physicians, nurses, and registration staff, as well as on-call physicians, regarding each group's familiarity with the EMTALA mandates. Among other things, respondents raised concerns about the cost of uncompensated care and difficulties with staffing on-call panels. The top five specialties mentioned as being of concern with respect to on-call coverage were: neurosurgery; cardiovascular surgery; pediatrics and subspecialties; orthopaedic surgery; and obstetrics/gynecology and neonatal services.

The second report, *The Enforcement Process*, examines the mechanisms by which the federal government enforces EMTALA and suggests areas in which HCFA can improve the process—increasing oversight of regional offices, improving data collection and access, and establishing an EMTALA technical advisory group.

The full text of both reports can be accessed on the OIG's Web site at <http://www.hhs.gov/oig/oei/whatsnew.html>.

In a regulation issued on January 18, HCFA confirmed its plans to change the Medicare and Medicaid hospital conditions of participation for anesthesia services. Under the new rules, state licensing laws will determine which professionals are permitted to administer anesthetics in hospitals and ambulatory surgical centers that participate in the Medicare and Medicaid programs. This change eliminates a federal requirement for physician supervision of certified registered nurse anesthetists who administer anesthesia in accordance with their scope of practice under state law. The published rule indicates the effective date is March 19. Because of a regulatory review plan announced by President Bush in the first days of his new administration, however, that date has been postponed by at least 60 days.

Objecting to the proposed change in Medicare rules, a coalition of nearly 100 national and state medical and surgical specialty societies, including the College, wrote to Health and Human Services Secretary Tommy Thompson on February 1, asking him to rescind the final rule until scientific evidence is available about the safety of changing the supervision requirement.

# What surgeons should know about...

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## The OIG'S compliance guidance for individual and small group practices

by Cynthia A. Brown, Associate Director, Health Policy and Advocacy Department

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) published guidelines in the *Federal Register* on October 5, 2000, which are intended to assist physicians in their efforts to comply with increasingly complex federal health program rules and policies. The OIG's *Compliance Guidance for Individual and Small Group Physician Practices* outlines a variety of business practices physicians may adopt that, in the agency's view, will help them avoid submitting erroneous claims or engaging in unlawful conduct.

The most recent guidelines were based on compliance material that the OIG issued previously for eight other sectors of the health care industry.\* Like those documents, the physician guidelines describe seven basic compliance plan elements:

- Conducting internal monitoring and auditing.
- Implementing compliance and practice standards.
- Designating a compliance officer or contact.
- Conducting appropriate training and education.
- Responding appropriately to detected offenses and developing corrective action.
- Developing open lines of communication.
- Enforcing disciplinary standards through well-publicized guidelines.

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\*Compliance guidance also has been issued for the following: hospitals, clinical laboratories, home health agencies, durable medical equipment suppliers, third-party billing companies, hospices, Medicare+Choice organizations offering coordinated care plans, and nursing facilities. All of these documents are available on the OIG Web site at <http://www.hhs.gov/oig> in the "Electronic Reading Room."

The physician compliance document is lengthy and includes a variety of detailed suggestions that are intended to be helpful for specific situations. As a result, it is not possible to provide a detailed summary of its contents here. Nonetheless, Fellows in solo and small group practices may find answers to the following questions helpful as they decide whether and how to implement compliance programs of their own.

**Q. Do these new guidelines impose new mandates or rules on my practice?**

**A.** No. Like the guidance documents issued by the OIG for other sectors of the health care industry, adoption of the compliance program elements described in the physician guidelines is voluntary. The agency issued the document in response to physicians' fears about the growing number of complex regulations imposed on them and the increased federal emphasis on monitoring and enforcing compliance.

**Q. Does the OIG really expect individual and small group practices to develop internal compliance programs that are as detailed and extensive as those used by hospitals and other providers, which have much greater financial and staffing resources?**

**A.** No. In fact the OIG notes that, "unlike other guidances issued...this guidance for physicians does not suggest that physician practices implement all seven components of a full scale compliance program." Because of their



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limited resources, the OIG intends for physicians to only consider adopting the document's step-by-step approach if they choose to develop and implement a compliance program. In other words, it provides the OIG's views on the fundamental components of physician practice compliance programs and suggests the principles that a practice might consider when developing its compliance program.

**Q. Given all the paperwork my office handles already, why would we voluntarily choose to implement a compliance program?**

**A.** According to the OIG, there are many good reasons for a physician practice to implement a compliance program:

- To speed and optimize payment of claims.
- To minimize billing mistakes.
- To reduce the chances that an audit will be conducted by the Health Care Financing Administration (HCFA) or the OIG.
- To avoid conflicts with self-referral and anti-kickback statutes.

Some possible benefits of implementing a compliance program are not explicitly stated. For example, physicians may assume that actively implementing an internal compliance program increases their chances of surviving any future audits by federal officials. At the very least, they hope that demonstrating a good-faith effort to comply with federal program rules will grant them some protection against severe monetary or criminal penalties if problems are uncovered.

The OIG makes no promises of immunity or favorable treatment. Instead, the agency only emphasizes its belief that adopting these recommended business practices will improve a practice's chances of complying with federal program rules. In that way, the guidelines offer physicians some measure of protection against future audits. In other words, the business practices proposed by the OIG may decrease the likelihood that a physician will commit errors or engage in activities that are likely to trigger an audit (or be discovered if an audit is conducted). The document also stresses that federal officials have neither the interest nor the authority to impose severe civil or criminal penalties on physicians who commit innocent billing errors.

**Q. How does the OIG define a "small" group practice?**

**A.** Mindful of the wide variety of physician practice types and settings, the OIG refrains from defining a small or large group based on the number of physicians involved. Instead, the agency states its intent to direct the guidance toward those physician practices with financial and staffing resources that are too limited to allow them to implement full-scale, institutionally structured compliance programs as set forth in the *Third Party Medical Billing Guidance* and other previously released material.

**Q. Assuming that my practice does develop a compliance plan, where do we begin?**

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**A.** The OIG recommends that physicians begin the process of developing a compliance plan by first reviewing their own experiences with billing problems and other compliance issues. This may involve examining claims that have been denied or that have resulted in repeated overpayments.

As part of the first element of a typical compliance plan (auditing and monitoring), the OIG recommends that bills and medical records be reviewed periodically for compliance with coding, billing, and documentation requirements. A baseline or benchmark audit should be conducted first to allow the practice to chart its compliance efforts and document changes in the number of claims paid or denied. This should be done shortly after education and training programs for practice personnel are completed. Following the initial self-audit, the OIG recommends that periodic audits be conducted at least once a year to ensure that the compliance program is being followed.

**Q. What happens if problems are identified through these self-audits?**

**A.** The OIG stresses that one of the most important components of a successful compliance audit protocol is “an appropriate response when the physician practice identifies a problem.” The guidelines note that these actions might include: (1) generating a repayment to Medicare or other appropriate payor from which an overpayment was received; or (2) consulting with a coding or billing expert to determine the next best course of action. According to the OIG, “There is no boilerplate solution to how to handle problems that are identified.” Nonetheless, it stresses that an effective compliance program must include a system for responding to and reporting potential problems and for maintaining and preserving records about problem issues and the subsequent responses.

**Q. Self-auditing and monitoring can help physicians uncover their practice’s risk areas. However, there are so many rules and regulations that may affect my practice. Does the OIG provide any direction about specific risk areas that merit particular focus beyond those problems we may have encountered already?**

**A.** To assist physicians in performing an initial assessment of their compliance risks, the OIG developed a list of four potential risk areas that merit particular attention for most practices.

- *Coding and billing problems.* The OIG cites many clearly fraudulent activities such as billing for items or services not provided or misusing provider identification numbers. Other potential problems may also arise due to inadvertent errors, such as submitting claims for services and supplies not deemed reasonable and necessary, unbundling procedures codes, and failing to use coding modifiers properly. The OIG states that written standards and procedures can help ensure that coding and billing are based on medical record documentation and properly reviewed for accuracy.

- *Documentation.* Timely, accurate, and complete documentation of diagnosis and treatment helps verify that bills submitted are accurate and appropriate. Medical records may also be used to validate the site of service, the appropriateness of the service, billing accuracy, and the identity of the caregiver. Surgeons should heed a phrase commonly used by HCFA staff: “If it’s not documented, it didn’t happen.”

- *Improper inducements.* Remuneration for patient referrals is illegal because it can distort medical decision making, cause overutilization of services, stifle competition, increase the costs of care, and harm quality of care. Consequently, the OIG strongly urges physicians to develop stan-



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## Resources on the Web

### HHS Office of the Inspector General

Compliance program guidance:

<http://oig.hhs.gov/medcomp/index.htm>

Advisory opinions:

<http://oig.hhs.gov/advopn/index.htm>

Anti-kickback and safe harbor information:

<http://oig.hhs.gov/ak/index.htm>

Fraud alerts:

<http://oig.hhs.gov/frdalrt/index.htm>

Individuals and entities excluded from federal programs:

<http://oig/hhs.gov/cumsan/index/htm>

### Health Care Financing Administration

Advisory opinions on self-referrals:

<http://www.hcfa.gov/regs/aop/>

Carrier contact information:

<http://www.hcfa.gov/medicare/incardir.htm>

Computer-based training:

<http://www.medicaretraining.com>

<http://www.hcfa.gov/medlearn>

Information for plans and providers:

<http://www.hcfa.gov/audience/planprov.htm>

Local medical review policies:

<http://www.lmrp.net>

dards and procedures that encourage compliance with anti-kickback and self-referral statutes. In particular, arrangements with hospitals, hospices, nursing facilities, home health agencies, durable medical equipment suppliers, pharmaceutical manufacturers, and vendors are areas of potential concern. The OIG generally recommends that physician practices consult with le-

gal counsel familiar with the anti-kickback and physician self-referral statutes before entering into business arrangements that involve making referrals. Also, problems may be raised by improper inducements made to patients in the form of waived coinsurance or deductible amounts without a good-faith determination of financial need.

- *Reasonable and necessary services.* Medicare pays only for items and services that meet its “reasonable and necessary” standards, and physicians should not bill the program for services that fail to meet them. However, physicians may bill Medicare to receive a denial for services if it is necessary to obtain reimbursement from a secondary payor.

**Q.** What is the correct way to bill Medicare when a claim denial is needed in order to receive payment from a secondary insurer for a service that doesn’t meet the program’s “reasonable and necessary” standards?

**A.** The Medicare claim should be completed as usual; if the patient signed an advanced beneficiary notice (ABN), the -GA modifier (waiver of liability statement on file) should be attached to the appropriate procedure code. If the carrier agrees that the service did not meet the “reasonable and necessary” standards, the physician will receive a denial notice on the remittance advice and the patient will receive a copy on the monthly summary notice. When filing the secondary claim, follow the insurer’s instructions for showing the denial.

Some Medicare carriers may have issued instructions that call for some or all claims on which a denial is sought to contain the procedure code A9270, “Noncovered item or service”; those or any other local instructions should continue to be followed.

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**Q. What other potential risk areas were identified by the OIG?**

**A.** There are, of course, a variety of program rules and procedures related to the four risk areas identified by the OIG; examples include the Correct Coding Initiative and the continually evolving Documentation Guidelines for Evaluation and Management Services.

In addition, the OIG cites other rules, statutes, and risk areas that physician practices may want to review and incorporate into their practice standards and procedures. These include local medical review policies, the Emergency Medical Treatment and Labor Act, Advance Beneficiary Notices, Certificates of Medical Necessity, teaching physician payment rules, gain-sharing arrangements with hospitals, physician incentive arrangements, use of third-party billing services, balance billing limits for nonparticipating physicians, professional courtesy, and unlawful advertising.

Each of these risk areas is described in some detail in an appendix to the compliance guidance. Separate appendices also describe civil and criminal statutes related to health care fraud and abuse.

**Q. Does the OIG offer any advice on how a small practice can keep track of all these rules?**

**A.** The OIG recommends that physician practices maintain a resource manual as a reference tool, using publicly available information. Such a “binder” may contain the practice’s written standards and procedures, relevant HCFA directives and carrier bulletins, and summaries of informative OIG documents, such as Special Fraud Alerts and Advisory Opinions. Much of this material is accessible through the Internet (see box, p. 11). In addition, the OIG and HCFA are working

to compile a list of basic documents issued that could be included in such a binder.

With regard to developing internal procedures and protocols, the OIG notes that practice management companies, independent practice associations, and other third parties frequently have written standards and procedures that can be adopted.

**Q. What recommendations does the OIG make with regard to involving practice personnel in a compliance program?**

**A.** An effective compliance program involves practice personnel in a variety of ways:

- A *compliance officer and contact(s)* should be identified to accept responsibility for developing corrective action plans, if needed, and for overseeing the practice’s adherence to that plan.
- *Appropriate training and continuing education* are needed for staff involved in coding, billing, and so forth. This might be obtained through another provider’s compliance program, such as hospital-based training sessions, as long as the physician practice avoids the appearance of referral inducement by paying fair market value for its participation.
- The OIG stresses that *enforcement and disciplinary provisions* are necessary to add credibility and integrity to a compliance program. Practice employees must understand that compliance is a condition of continued employment and that adherence to the compliance plan’s standards and procedures will not get them into trouble.
- *Open lines of communication* must be maintained to prevent problems from occurring and to encourage productive discussion about problems that do occur.





John H. Gibbon, Jr., Lecture:

# Leadership in medicine

by  
John Waldhausen, MD, FACS,  
Hershey, PA



## John H. Gibbon, Jr., Lecture: Introductory remarks

by Frank C. Spencer, MD, FACS, New York, NY



**I**t is a strong pleasure to have the honor of offering the following introductory remarks regarding Dr. John Waldhausen's presentation of the John H. Gibbon, Jr., Lecture at the 2000 Clinical Congress.

Dr. Waldhausen and I met during surgical residency training at Johns Hopkins over 40 years ago. I was a chief resident; he was an intern and, hence, my responsibility. This started a lifelong warm, professional, personal friendship. I attended his Baltimore, MD, wedding to Marian, later followed his academic star with both interest and pride, and had the honor, following his firm instructions, of performing a coronary bypass on him at two different times.

Dr. Gibbon would have been most pleased that John Waldhausen gave this lecture in his honor. Their careers have some remarkable similarities, both overcoming seemingly impossible obstacles with persistent hard work.

Dr. Gibbon's story is legendary. In the mid-1920s, he was in surgical training at the Massachusetts General Hospital in Boston. After staying all night with a patient dying from a pulmonary embolus, he started a seemingly impossible lifelong quest to build a heart-lung machine. After 20 years with little progress, his laboratory was removed. I think that means he was "fired!" Undaunted, he returned to Philadelphia, continued his laboratory work, and subsequently performed the first successful open-heart operation in 1953.

John Waldhausen's father was a German businessman, but John was born in New York City and, hence, is an American citizen. On the eve of World War II, when John was about 10 years old, his father was ordered back to Germany. Hence, he finished high school in Germany during World War II. After the war, he wanted to get a scholarship to

continue his education in the U.S., but no college wanted him. You can imagine the enthusiasm in this country in 1946 for an American-born German student with no money!

Fortunately, a Jesuit priest who knew of John's ability and potential intervened. (The Jesuits are widely respected and admired for their strong commitment to education.) This led to John's entering the College of Great Falls, MT, at age 18, probably with the shirt on his back and 50 cents in his pocket.

The rest is history: medical school in St. Louis; residency training at Hopkins, the National Institutes of Health, the University of Pennsylvania, and the Indiana University; followed by faculty positions at Indiana and the Children's Hospital of Philadelphia and the University of Pennsylvania. In 1969, at age 40, he ventured with others to a cornfield near Hershey, PA, to start a new medical school at the Pennsylvania State University, where he founded the department of surgery and served as its chair for 25 years.

He recently finished his five-year term as editor of *The Journal of Thoracic and Cardiovascular Surgery* and is currently the John Oswald Professor of Surgery Emeritus at Hershey. He has been an active member of the American College of Surgeons for over 30 years, is a member of numerous surgical organizations, and was president of the American Association for Thoracic Surgery in 1991. His bibliography includes more than 230 papers and over 40 books and chapters.

He and Marian have three sons—John, Robert, and Gordon—one of whom is firmly launched in his early surgical career at the Children's Hospital of Seattle and the University of Washington.

Hence, with obvious great pleasure, I present the 30th Gibbon Lecture, by Dr. John Waldhausen. □



# John H. Gibbon, Jr., Lecture: Leadership in medicine

by John Waldhausen, MD, FACS, Hershey, PA



John Gibbon, Jr., MD, FACS, was perhaps the most important person in the development of cardiac surgery in the past 50 years. The heart-lung machine, which allowed surgeons to operate on the quiet, open heart while the patient was sustained in all other vital functions, was the pivotal development that made modern heart surgery possible. Gibbon pursued this dream for more than 20 years—from animal experiments to final successful use in an 18-year-old woman.<sup>1</sup>

Fittingly, the subject of this article is leadership in medicine, as Dr. Gibbon exemplified leadership to the fullest extent. He established direction with a vision for the future. He aligned the people needed to fulfill his dream, motivated them to overcome its many obstacles, and persevered until the task was successfully completed.<sup>2</sup>

Leadership in medicine has never been more important than it is today. The corporate model in medicine has become ever more common, and physician groups, health maintenance organizations (HMOs), and other health plans truly rival many Fortune 500 corporations in size and financial capacity.

When medicine was practiced by solo practitioners or small groups and fee-for-service was the prevailing method of payment, the need for leadership was not paramount. Only large group practices, such as the Mayo and Cleveland Clinics, or large professional organizations, such as the American College of Surgeons or the American Medical Association, required leadership. This picture changed dramatically after World War II, with the widespread introduction of health insurance, especially Medicare and Medicaid, in which the U.S. government began to play an ever-increasing role.<sup>3</sup> The introduction of managed care

brought still more advances in the development of what Arnold Relman calls the “new medical industrial complex,”<sup>4</sup> with seismic changes that we still experience today and will experience for some time.

Yet, almost daily we hear of the disastrous breakdowns of many of these health care systems, and even a cursory analysis shows that poor leadership, in addition to poor management, is the cause. Only three years ago, a major academic institution merged with a private clinic. On paper this marriage looked solid and would have been of great financial and educational benefit to the medical school. Yet, today the divorce is final and will cost millions of dollars. Why? Because of poor leadership. If those in charge had a vision, they clearly were unable to impart it to others. The initial enthusiasm of department chairs and others was quickly dispelled when they discovered that they were to be excluded from the planning and development phases of the combined health system and from the decision making process as well. Instead of motivating and encouraging these department heads, those at the top merely sent down orders from on high from their isolated and distant corporate headquarters. While physician's salaries were reduced and personnel were laid off because of mounting deficits, the chief executive officer (CEO) accepted a significant personal salary increase. Similar events have occurred in many other places—all for lack of leadership.

But what is leadership? As Warren Bennis said: “To an extent, leadership is like beauty. It is hard to define, but you know it when you see it.” Much has been written on this subject, and much is probably not true. Wiley Souba, MD, FACS, recently offered a good summary of what a number of indi-

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viduals from different walks of life have said.<sup>5</sup> I like this description: Leadership defines what the future should look like, aligns people with that vision, and inspires them to make it happen despite obstacles.<sup>6</sup>

Leadership is not a mystical characteristic bestowed upon a few at birth, although it is evident that some have a greater natural aptitude for the role of leader, just as some have a greater aptitude for playing the piano. But only with development of these propensities, their continued use, and fine honing will a true leader or Vladimir Ashkenazy emerge. In that sense, both are an art that must be learned and continually practiced.

Leadership is not charisma, nor is it the same as management, though both may contribute to leadership. Management and leadership have two distinct roles and both are essential to the success of any enterprise. Management means coping with complex organizations and ensuring that things run well, that everyday problems are dealt with, and that there is a steady and continuous performance of the whole. Leadership, on the other hand, requires dealing with change, often unanticipated, whether it comes from external forces, such as HMOs and government, or from internal forces, such as the development of new technology or systems requiring new knowledge and expertise.

Harvard Business School's John Kotter defines leadership by what leaders do: they cope with change, they set direction, they align people to participate in that new direction, and they motivate people.<sup>6,7</sup> Jack Welch, the CEO of General Electric and one of the most successful leaders in industry, says he has three jobs: selecting the right people, locating the capital resources, and spreading ideas quickly.<sup>8</sup> Thus, a leader empowers managers (departmental chairs or chiefs) to become leaders in their own units consistent with the overall goals of the institution.

It has been estimated that only 10 percent or less of the brain power of the employees in any given enterprise is used.<sup>8</sup> What a waste! We cannot afford such underutilization, nor is it fair to those who have committed themselves to the goals of our institutions or groups. In today's world there is no place for the concept that strong leadership is evidenced by an autocratic leader making decisions and telling his subordinates what to do. Louis the XIV's statement: "L'etat c'est moi" ("I am the

state") is now a prescription for failure.

Warren Bennis believes leaders should be catalysts.<sup>8</sup> He concludes that in all organizations—whether corporate, military, or political—constituents seek four ideals: meaning or direction, trust in and from their leaders, a sense of hope and optimism, and results. How true when we think of some of America's greatest presidents—Washington, Lincoln, and Theodore and Franklin Roosevelt. As the ancient Chinese philosopher said: "The wicked leader is he who the people despise. The good leader is he who the people revere. The great leader is when the people say 'we did it ourselves.'"

If we intend to survive as a true profession today, we must recognize the need for change or, even better, initiate it. This requires leadership. A leader must have a vision, must communicate this vision to his or her colleagues, and must motivate and inspire them as a team that will succeed in accomplishing these changes.<sup>2</sup>

Change in medicine, as in all other fields, is inevitable, and if we as physicians close our eyes to that inevitability, we will be tossed by the wayside. No longer is the title "Doctor" one that inspires automatic deference and acceptance.

Kotter speaks of eight errors common to efforts toward organizational change and their consequences. His formulations are from and for the business world, yet they also hold true for our own world.<sup>6</sup> They are:

- Allowing too much complacency.
- Failing to create a sufficiently powerful guiding coalition.
- Underestimating the power of vision.
- Under-communicating the vision by a factor of 10 (or 100 or even 1,000).
- Permitting obstacles to block the new vision.
- Failing to create short-term wins.
- Declaring victory too soon.
- Neglecting to anchor changes firmly in the corporate culture.

But why must we as physicians lead? Why not leave it to administrators who are educated and trained in this corporate world? Why not let us do what we were educated and trained to do? Allow us to practice medicine, and let them administer. I believe this is a prescription for disaster and ultimately will work to the great disadvantage of patients. Medicine is not a business, and the differ-



ences between it and a commercial enterprise are profound, although perhaps less well-defined in the current entrepreneurial climate when compared to earlier times.<sup>2,4,10</sup> Who knows better what medicine is all about? Who knows better the core values of medicine and the need for medical education and research than we? These values are part of us; they have been instilled into our being from the day we entered medical school and have been reinforced over the next decade or longer, and this has not changed! Would one give command of an army to an individual well-educated in the realm of logistics, supplies, and strategy but who had never served as soldier or officer?

There is no question in my mind that the best CEOs for medical enterprises are physicians. Physicians not only know medicine, they understand the core mission upon which all else is based. Some have given as justification for physician control over the delivery of health care their supposed moral superiority.<sup>11</sup> This is self-serving and misses the point. It is not that we are necessarily morally superior to any one, but that we understand medicine and that we have been part of the core values of medicine: the welfare of patients, the education of students and residents, and the need for research. This is our professional life. These are the commitments underlying our profession. These values earn the physician leader the kind of respect from his fellow physicians that is reserved only for those of the same professional background.

This is not to say that we can take any well-respected physician, no matter how good a practitioner, and turn him or her into a CEO. He or she must develop skills in management and leadership comparable to those with MBAs. And, this is precisely the problem; some institutions have appointed nonphysician CEOs who do not understand the essence of medicine and who will make decisions that, in the long run, are inconsistent with the mission of the unit. They have managed it as a pure business, and although the pressures to do so are great, it is essential to remember that our primary reason for being is not profit but patient care.

Meanwhile, MD-CEOs have been appointed who don't know how to lead, who haven't the background to deal with the challenges of change, let alone manage the enterprise, and who have nei-

If we intend to survive as a true profession today, we must recognize the need for change or, even better, initiate it.



ther a vision nor the ability to convey a vision, and if they have these qualities, no capacity for enlisting the support of those needed to turn that vision into a reality. Hence, this is not to say that non-MDs should have no role in the control of health care delivery. Indeed, in many areas lay managers will be superior to us, and should be: in finance, management of support services, and construction, among others. But leadership and direction, the setting of priorities, must come from physicians.

How, then, is the future "MD-CEO" to be identified and educated? Medical education is already inordinately long, and to take successful physicians away from their practice and income is difficult. We might look briefly at what other organizations and professions have done. The army has had an outstanding record in this regard, as exemplified by American generals in World War II. These officers did not just appear mysteriously, but had been carefully nurtured to take on the huge tasks of landing troops thousands of miles from home, leading them into combat, and keeping them supplied.

It is of interest that the modern concept of educating officers for high command arose only after



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a disastrous military experience. In 1806, Napoleon totally defeated the Prussian Army, thought to be the best in Europe. Warfare had changed dramatically with the French Revolution and the subsequent appearance of huge armies of 100,000 men or more. Traditionally, as in Prussia, the leadership of an army had been in the hands of a prince or another noble often of inconsistent or even questionable leadership abilities. A group of young officers and reformers came to believe that Prussia could no longer afford this gamble, but had to educate some of its officers specifically for high command. With the reorganization of the War Academy in Berlin under Karl von Clausewitz, one of the greatest military thinkers and the author of *On War*,<sup>12</sup> and with the development of a general staff of officers highly trained in all aspects of warfare surrounding the commanding general, a new era was brought about with astounding military results. Parenthetically, it might be noted that the second recommendation of the Prussian reformers, to establish a constitutional monarchy with a parliament, was not accomplished and had disastrous consequences for that country as well as for the world.

Virtually all countries followed the Prussian example. The United States was actually quite slow in doing so, but in the 1890s established the Army War College in Carlisle, PA. Almost all future commanding officers would at some point pass through the "Carlisle Barracks" for a period of time.<sup>13</sup>

Today, officers displaying promise for command are initially assigned to army units, then spend several months or more in Carlisle or other command schools. Some even go on to earn PhDs at universities, all in the quest for future leaders.

Industry has learned similar lessons. After the initial explosion of industrial expansion in the second half of the 19th century, led by such entrepreneurs as Rockefeller, Carnegie, and Ford, companies found themselves in need of continuing high levels of management and leadership. Many did not find such and, therefore, did not survive. About 100 years ago, business schools such as the Wharton School of the University of Pennsylvania and the Harvard Business School evolved. Most major universities followed suit, and today an ever-increasing number of the leaders of industry are graduates of these schools.

What can medicine do? A number of physicians

have gone to business school and obtained MBAs, which is a two- to three-year process and adds significantly to their educational period. Furthermore, although these programs ground the individual in the fundamentals of management and leadership, some of the specifics related to health care are only partially covered. Noren and Kindig give an excellent up-to-date summary of the status of physician executive development and education.<sup>14</sup> They point out the need for preparation by practical experience for the physician-executive. In addition to a formal educational program, such hands-on preparation is essential because of the diversity and complexity of organizations, people, and professions to which physician executives must effectively relate. Indeed, in the past this was the only method available to future executives and obviously produced some outstanding leaders. Noren and Kindig further point out that two key elements cannot generally be obtained without substantial direct experience: clinical insight and professional leadership competence. Without clinical insight the physician executive does not differ significantly from the nonphysician executive.

In recent years the Thoracic Surgery Research and Education Foundation has initiated a program for cardiothoracic surgeons within the Kennedy School for Public Policy at Harvard University. Surgeons spend from two weeks to as much as two years in this study. The foundation provides a stipend. Although two weeks are obviously inadequate for a future CEO, the experience is of great help to those with administrative positions at the middle level, such as division chiefs and medical directors, especially if such courses are repeated at intervals and at higher levels of sophistication.

It is my firm belief that this sort of program will become even more essential in medicine as the transformation to the corporate model becomes ever more prevalent. Let me stress: the mere placement of MDs in CEO positions will not be sufficient. It has already been questioned on the grounds that we lack the necessary background for these positions. Furthermore, our supposed "moral superiority" is not apparent in the light of current evidence that some physician-led HMOs have supposedly "defrauded" the government, and many physician-owned enterprises have primarily ben-

effitted the physicians. They say until pressured by government or the insurance industry, physicians have not been self-disciplined and judicious in the use of medical technology and treatment.<sup>9,15</sup> It is not our moral superiority but our commitment to the core missions of our profession, based on the priority of patient care, that make us more suited for leadership in medicine.

The future leaders in medicine, in my view, will be fully medically educated and trained physicians with five to 10 years of clinical experience who, either by self-selection or other processes, direct their careers toward leadership positions. They will enter formal programs at universities, designed specifically to add to the leadership capabilities of the future CEO or medical administrator for a minimum of six months to a year, possibly interspersed with a return to administrative and clinical duties for one or two years.

The American College of Surgeons should be commended for initiating a postgraduate course on these matters, but more extensive courses are needed. Such programs should not and generally cannot be underwritten by individual trainees. Support must come from the ultimate beneficiary of these new leaders—medicine. To that end the Thoracic Surgery Research and Education Foundation has set an example. I believe it would be of great benefit to all medicine were the American College of Surgeons, the American College of Physicians, the American Medical Association, and others to undertake a similar program. It fits with the College's mission of education and ultimately will benefit our patients—the final essence of who and what we are and what we stand for.

Such programs should also be supported by matching funds to be given by the parent medical institution of the candidate. It must be recognized that we are not talking about small numbers of individuals needed for leadership positions. If we as a profession fail to provide leadership, someone else will fill this void. As Harold Shapiro, president of Princeton University, has so aptly put it: "A willingness to accept the risk of failure is one of the costs of leadership and, therefore, the price of all success."<sup>16</sup>

This article is an edited version of the John H. Gibbon, Jr., Lecture, which was delivered October 23, 2000, at the ACS Clinical Congress in Chicago, IL.

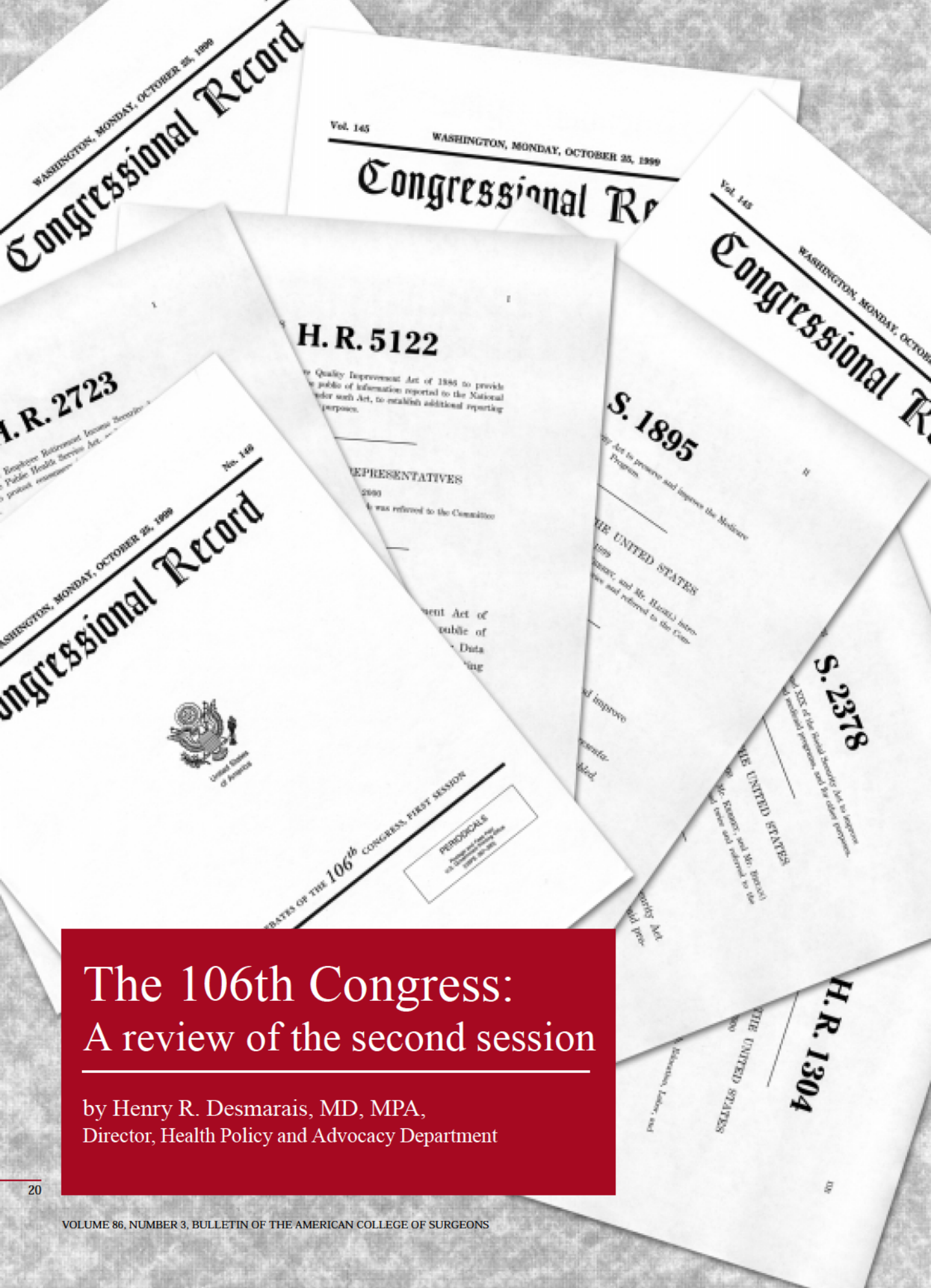
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# The 106th Congress: A review of the second session

by Henry R. Desmarais, MD, MPA,  
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**T**he 106th Congress finally came to an end on December 15, 2000. The Senate adjourned at 8:03 pm, and the House followed suit at 8:41 pm. It was not necessarily a model Congress. While it did produce legislation of significance for surgeons and their patients, unfortunately it also failed to approve or even consider several other important matters.

Early last year, I provided a report about the first session of the 106th Congress.<sup>1</sup> A little later, I reviewed the key issues confronting the Congress during its second session, focusing especially on patient safety, patient protection, patient confidentiality, Medicare reform, and collective bargaining by physicians.<sup>2</sup> This article completes the story by providing a report about the outcome of this second session of the 106th Congress.

### ***Patient safety***

As the year began, there was some trepidation that concerns about medical errors, prompted by the considerable publicity accorded a major report by the Institute of Medicine, would prompt Congress to "do something," whether it made sense or not. In particular, it certainly seemed possible that Congress would create a nationwide mandatory reporting system for the collection of standardized information about adverse events that result in death or serious harm to patients, as recommended by the Institute of Medicine report.<sup>3</sup> In fact, a bill introduced by Senators Charles Grassley (R-IA) and Joseph Lieberman (D-CT), S. 2378, the Stop All Frequent Errors in Medicare and Medicaid Act of 2000, essentially called for just such a mandatory system.

In the end, however, Congress approved only modest steps, providing an additional \$50 million to the Agency for Healthcare Research and Quality (AHRQ) for patient safety research and related activities. It deferred action on other more difficult issues. This outcome is probably not all bad. The College was among the first organizations to caution against precipitate action. On February 22, 2000, Thomas R. Russell, MD, FACS, the College's Executive Director, appeared before a joint session of the Senate Health, Education, Labor and Pensions (HELP) Committee and the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies. In his testimony, Dr. Russell asserted that the Con-

gress should not create a mandatory reporting system. Instead, he urged the Congress to adopt legislation that would extend peer review protections (that is, confidentiality protection and protection from discovery) to all data and work products related to patient safety and quality improvements. Dr. Russell noted that, in the College's view, this was the step that would be likely to bear immediate dividends with respect to patient safety, as it would, among other things, encourage the development and successful operation of voluntary reporting systems.

Later in the year, key members of the HELP Committee introduced two separate bills addressing patient safety concerns. Senators Jim Jeffords (R-VT) and Bill Frist, MD, FACS (R-TN), sponsored the Patient Safety and Errors Reduction Act, S. 2378, while Senators Edward Kennedy (D-MA) and Christopher Dodd (D-CT) authored the Error Reduction and Improvement in Patient Safety Act, S. 2743. While the two bills differed in important ways, it was rather significant that both called for voluntary, rather than mandatory, medical error reporting systems. Both bills also would have established a Center for Patient Safety within AHRQ and provided strong federal peer review protections for medical error-related information. These protections closely mirrored a set of general principles developed during the spring and summer by a broad-based coalition of health care organizations, including the College. Additionally, the Kennedy-Dodd legislation would also have required the new Center for Patient Safety to establish "best practices" based on information gathered through the reporting system, and authorized the Secretary of Health and Human Services (HHS) to determine which of them to apply to federal health care programs, such as Medicare.

Although the 106th Congress did not adopt a comprehensive program to address patient safety, it seems likely that the issue will be back on the agenda in 2001. During a September 18, 2000, meeting with the College's Patient Safety and Professional Liability Committee, congressional staff representing both Senators Jeffords and Kennedy made clear they were already beginning to plan for this possibility.

### ***Patient bill of rights***

Throughout the year 2000, the College continued to push for enactment of strong patient protection legislation (that is, managed care reform

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or patient bill of rights legislation). We did this through the many ACS Chapters that sent representatives to Washington as part of the Capitol Hill Visit Program (19 of them in 2000 alone), and through the members of the College's Congressional Action Program, a growing cadre of Fellows committed to serving as the College's grassroots army.

Our preferred approach for providing patient protections was a House-passed bill, the Bipartisan Consensus Managed Care Improvement Act, H.R. 2723, authored by Representatives Charlie Norwood (R-GA), John Dingell (D-MI), and Greg Ganske, MD, FACS (R-IA). Our support for this bill surprised some Fellows, largely because the proposal was supported by far more Democrats than Republicans. However, this bill was much stronger than the bill passed by the Senate in 1999, and its protections would have applied to many more patients.

Among other provisions, H.R. 2723 would have prohibited so-called gag rules and required health plans to use a "prudent layperson" standard when determining coverage for emergency care services. It also would have mandated that health plans ensure access to needed specialty care and permit independent external review of coverage and treatment decisions. Its most controversial provision would have held health plans liable for their medical decisions, rather than allowing them to be shielded by the current broad interpretation of the Employee Retirement Income Security Act (ERISA). Of course, those supporting this provision were not doing so out of a love affair with malpractice suits. Instead, proponents believed that the litigation option would cause most health plans to "clean up their act" in order to avoid litigation. At the same time, health plans and physicians would find themselves on a more level playing field with respect to liability. In fact, earlier in 2000, at a key point during congressional deliberations, the College felt compelled to send a letter urging Congress not to enact a managed care reform bill that would provide for different levels of liability for health plans and physicians (for example, by limiting noneconomic damages for health plans to some maximum dollar amount, without doing the same for physicians).

In any case, what the Congress needed to do during its second session, at least in theory, was to

reconcile differences between the two bills passed by the House and Senate in 1999. The legislative wheels grind slowly, however, and the outcome was uncertain until very late in the session. The usual House-Senate conference process for resolving differences failed, probably because there was insufficient interest in making it work. In fact, at many points during the year, pontificators and pundits of varying political stripes would argue that few in Congress really wanted a resolution. Some said that the Democratic Party just wanted a campaign issue. Others alleged that many Republicans were primarily interested in protecting the interests of their campaign contributors (that is, the insurance companies, giant managed care organizations, and big business). In the midst of all of these pronouncements, it was difficult to determine the truth. Certainly, much time, effort and money was spent by both proponents and opponents of patient protection/bill of rights legislation. And, at a critical point in the debate, the President announced that he would simply promulgate regulations providing some of the patient protections being discussed—and that he would do so before the November elections! It was an obvious political slap at a gridlocked Congress.

Given all of this pressure, the Congress made one more valiant effort. A wide variety of deals were negotiated and renegotiated. However, in the end, negotiators were unable—or perhaps simply unwilling—to reach a compromise. This issue will almost certainly be taken up by the 107th Congress, perhaps even before this article is published in the *Bulletin*.

### ***Medicare payment policies***

Congress failed to act on another matter of importance to surgeons and their patients—providing relief on Medicare practice expense relative value units (RVUs). New, lower practice expense RVUs are being phased in for many surgical services by Medicare and other third-party payors. While Congress had directed the Health Care Financing Administration (HCFA) to refine these new values prior to their full implementation, the agency has made relatively little progress in this effort.

The College joined a coalition of about 30 medical and surgical specialty societies to promote a legislative remedy for this problem. This proposal



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would have halted the transition to new practice expense RVUs at the midway point—a 50/50 blend of “old” and “new” practice expense RVUs for most services. Exempted from this would have been 19 office-based evaluation and management services, including new and established office visits, office consultations, and eye visit services, whose practice expense values would have been allowed to rise. The resulting net increase in Medicare payments would have been covered from the budget surplus, rather than through another redistribution of Medicare payments from other services.

There was some hope that this proposal would be acceptable because it did not harm the primary care physicians (in fact, many would have benefited from the 50/50 blend of “old” and “new” values for services other than the 19 exempted, while still receiving anticipated RVU increases for evaluation and management services) and because Congress was already contemplating using the federal budget surplus to restore previous Medicare cuts. Hopes soared further when the College and its coalition partners successfully convinced the American Medical Association’s (AMA’s) House of Delegates to approve a resolution placing the AMA squarely in support of the proposal rather than remaining a neutral bystander.

As time passed, however, it became clear that this effort would be much more difficult. Several primary care specialties opposed the proposal. Moreover, policymakers eventually decided to devote a large proportion of the budget surplus to paying down the national debt, leaving far less to spend on other things. The College and its coalition partners responded by developing a less costly, alternative proposal, one that would provide for a three-year halt in the practice expense RVU transition, rather than a permanent one, with the assumption being that this would give HCFA more time to make necessary refinements in the new practice expense RVUs. It would also, of course, give interested parties more time to lobby policymakers for more permanent relief of one kind or another. Even this more modest proposal found no congressional takers.

Instead, Congress passed legislation requiring yet another study of Medicare’s RVU methodology. The College and its specialty society allies attempted to convince Congress that this study would only make sense if it were accompanied by at least

a temporary freeze on current practice expense RVUs. However, in the end, Congress would have none of this. Thus, the new practice expense RVUs continue to be phased in, which means that Medicare is using a 25/75 blend of the “old” and “new” values for 2001.

Fortunately, another College initiative did have a positive impact on most surgical specialties. This involved the refinement of practice expense RVUs for several evaluation and management services, including office visits. These RVU refinements (that is, reductions) had the effect of freeing up RVUs for allocation to other services, including surgical procedures. Another College initiative aimed at improving work RVUs for many surgical services is ongoing and appears promising. Any new values would be implemented beginning January 1, 2002.

Although Congress did not provide relief on Medicare practice expense RVUs, it did approve Medicare payment provisions benefitting hospitals (including teaching facilities), nursing homes, home health agencies, and Medicare + Choice plans. For example, teaching hospitals will benefit from provisions that will: maintain the indirect medical education adjustment factor at the current 6.5 percent for two more years, increase the proportion of hospital bad debt that can be reimbursed by Medicare from 55 to 70 percent, and provide the full market basket increase for 2001 hospital inpatient services.

### ***Trauma-related issues***

The College persuaded Congress to earmark \$3 million in fiscal year 2001 to fund the Trauma Care Systems Planning and Development Act. This program authorizes the Secretary of Health and Human Services to award grants to states to assist them in planning, implementing, and developing comprehensive trauma care systems, taking into account the College’s guidelines for optimal care of injured patients. Our success was not easy, especially given all the competition for federal funds, and the fact that the relevant appropriations bill had plenty of unrelated political problems. College staff, most especially Christopher Gallagher, the Senior Government Affairs Associate in the Washington Office, worked relentlessly to coordinate the efforts of other interested groups, enlist the help of the College’s Committee on



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Trauma, and educate innumerable congressional staff members. Eventually, the College was able to garner public support for this initiative from more than 100 members of Congress and over half of all U.S. senators.

In a related area, the College also lent its support to another successful legislative effort: adoption of a federal definition of drunken driving based on a blood alcohol level of 0.08 percent, with states given time to come into compliance (before facing the loss of federal highway funding if they do not). In this fight, traffic safety groups faced very powerful opponents, including alcohol and restaurant lobbyists and even the National Governors' Association.

Finally, the College supported the efforts of the American College of Emergency Physicians in securing a government study of the problems facing many physicians due to their expanding obligations under the Emergency Medical Treatment and Labor Act (EMTALA). As a result, Congress mandated that its investigative arm, the General Accounting Office (GAO), study the effect of EMTALA on hospitals, emergency physicians, and physicians covering emergency department call throughout the U.S. Among other issues, GAO will be expected to look at the level of uncompensated care costs that are being borne by hospitals and physicians as a result of the EMTALA statute and implementing regulations.

### ***"Cats and dogs"***

In congressional parlance, the term "cats and dogs" refers to those miscellaneous provisions in a larger bill that cover a wide range of matters. While the term is sometimes viewed as implying that the provisions in question are relatively unimportant, this often is not the case, at least from the perspective of those demanding congressional action on some issue. For purposes of this summary of the second session of the 106th Congress, I thought the term "cats and dogs" would serve as a catchy way to introduce a discussion of a wide variety of congressional actions, not to mention congressional inaction on other matters.

In the good news department was congressional inaction on a proposal to allow public access to the National Practitioner Data Bank (NPDB), the federal repository of malpractice data and information about disciplinary actions taken by hospitals

and others against physicians and other health care practitioners. Retiring Rep. Tom Bliley (R-VA) authored the bill in question, H.R. 5122, the Patient Protection Act of 2000. Some saw Representative Bliley's proposal as a vengeful response to the physician community's—especially the AMA's—support for a comprehensive Patient Bill of Rights. On September 20, 2000, Representative Bliley, the outgoing chair of the House Commerce Committee, convened a public hearing to consider his bill. However, he found little enthusiasm for the proposal, even among his own Commerce Committee colleagues, with Rep. Greg Ganske, MD, FACS (R-IA), being especially vocal in his opposition. Among other things, opponents questioned the quality and value of the data that would be shared with the public. In the end, Congress failed to act on the Bliley bill, leaving access to the NPDB as it was—limited to health plans, hospitals, and a few other selected entities.

The second session of the 106th Congress also saw President Clinton sign the Breast Cancer Research Stamp Reauthorization Act, authored by Sen. Dianne Feinstein (D-CA) and Rep. Charlie Bass (R-NH). The College strongly supported the legislation, which continues the practice of allowing a surcharge of up to 25 percent above the value of a first-class stamp, with the surplus revenues going to breast cancer research. The original idea of selling a stamp to raise money for breast cancer research was conceived by Ernie Bodai, MD, FACS, a general surgeon currently practicing in Sacramento, CA. First passed into law by Congress in August 1997, the program has raised more than \$15 million for breast cancer research, and its 40-cent stamp (first issued in 1998) has become the second highest selling stamp in postal service history. The new legislation provides a two-year extension of the breast cancer research semipostal and also includes a provision preventing the money raised from the sale of the stamps from being deducted from other federal funds that a research institute receives.

On June 30, 2000, the House of Representatives approved a bill that would have permitted independent physicians to negotiate collectively with their health plans. The vote was 276 to 136. The House-passed bill was an amended version of H.R. 1304, the Quality Health Care Coalition Act authored by Representatives Tom Campbell (R-

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CA) and John Conyers, Jr. (D-MI). Unfortunately, this was the end of the road for the measure. Strong opposition from Senate Republican leaders and end-of-the-session gridlock prevented further action. Now that Representative Campbell has been defeated in his bid to unseat Sen. Dianne Feinstein, it remains to be seen whether the issue of collective negotiating by self-employed physicians will find another congressional champion. The College was among the physician organizations that supported H.R. 1304 throughout the 106th Congress.

My March 2000 article in the *Bulletin* discussed at some length the contents of a comprehensive Medicare reform proposal, S. 1895, authored by Senators John Breaux (D-LA) and Bill Frist, MD, FACS (R-TN). Among other things, the bill called for a competitive Medicare premium system, involving both private and government-sponsored health plans, modeled after the Federal Employees Health Benefits Program, and appointment of a seven-member Medicare Board to administer the competitive system. I noted then that the Breaux-Frist bill would likely be followed by others, and that the most likely outcome would be deferral of major Medicare reforms until after the November 2000 elections. In fact, the 106th Congress not only deferred action on comprehensive Medicare reforms, it even failed to agree on legislation improving Medicare coverage for prescription drugs, despite strong public support. The Medicare reform issue will be back. The challenge for policymakers will be finding a way to assure the continued solvency of the Medicare program without compromising patient access to high-quality care. Given continued turmoil in the managed care component of the Medicare program, Medicare+Choice, this would seem to be a very tall order but one in which the surgical community will need to take an interest.

Finally, another matter not addressed by the Congress in 2000 was patient medical record confidentiality. Instead, the Congress appeared to prefer to await the release of final regulations on the subject, recognizing that these rules would have a delayed effective date that would give Congress plenty of time to intervene. These final rules and accompanying preamble, together exceeding 365 pages of fine print, were issued on December 21, 2000. The College was among the organizations that submitted detailed comments about the pro-

posed patient confidentiality regulations published on November 3, 1999. At this writing, College staff and consultants are reviewing the new regulations, which give most covered entities a full two years to come into compliance. Given the far-reaching nature of the new regulations, the new Congress could very well intervene in some fashion to require revisions or further delay, or even suspend, their enforcement. A future *Bulletin* article will provide more information about the new national standards to protect patients' personal medical records.

### **Concluding note**

One Congress ends and another soon begins, and the same issues have a way of coming back. This year, the College plans to redouble its efforts to recruit Fellows for our Congressional Action Program. And, changes in the College's Web site will, we hope, facilitate surgeon involvement in matters that are before the Congress. While the College's leadership and staff make every effort to represent the Fellowship, we know full well that our work has little chance of bearing fruit unless members of Congress believe that the people "back home" really care. That's where individual surgeons and their patients play a crucial role.

On behalf of Dr. Russell and the rest of the College's leadership, I'd like to thank all of those who contributed to the College's advocacy efforts during 2000. This includes the College's chapters, College committees, the members of our Congressional Action Program, and countless other Fellows of the College. I'd also like to acknowledge the hard work of the College's Washington staff, especially Cindy Brown, Associate Director of the Health Policy and Advocacy Department, and the critically important support of our many colleagues in the College's Chicago headquarters. □

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2. Desmarais HR: The U.S. Congress in Y2K: Will surgical patients benefit? *Bull Am Coll Surg*, 85(3):13-17, 2000.
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# Ten specialty boards report accomplishments and plans:

## Part I

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the *Bulletin* to keep Fellows abreast of any changes in the procedures of the various boards. The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the *Bulletin* contains the reports of the American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, and the American Board of Orthopaedic Surgery. The April issue of the *Bulletin* will feature the reports of the American Board of Otolaryngology, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.



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# American Board of Colon and Rectal Surgery

by Herand Abcarian, MD, FACS, Chicago, IL

The American Board of Colon and Rectal Surgery (ABCRS) held its annual meeting on September 24, 2000, and its interim meeting March 19, 2000, in Chicago, IL. During the annual meeting, new officers were elected for 2000-2001. They are: Richard L. Nelson, MD, FACS, president; Ian C. Lavery, MD, FACS, vice-president; and Herand Abcarian, MD, FACS, executive director.

Meanwhile, Bruce G. Wolff, MD, FACS, was newly elected to the board. Dr. Wolff replaces David Rothenberger, MD, FACS, who completed eight years of board service as of the September 24 meeting. Dr. Rothenberger served as president in 1999 and was the examination committee chair from 1997-2000. As examination chair, he made numerous improvements to both the written and oral examination processes.

The following individuals retained their board seats: Richard P. Billingham, MD, FACS; James W. Fleshman, MD, FACS; Robert D. Fry, MD, FACS; Philip H. Gordon, MD, FACS; Vendie H. Hooks, MD, FACS; Donald L. Kaminski, MD, FACS; John P. Roe, MD, FACS; Alan G. Thorson, MD, FACS; and Dr. Wolff.

## **Associate examiners**

The board maintains a slate of associate examiners whose terms rotate at different intervals. Currently there are 16 associate examiners. They are: P. Sue Beckwith, MD; John G. Buls, MD; Marcus Burnstein, MD; Jose Cintron, MD; Susan Galandiuk, MD, FACS; Francis J. Harford, MD, FACS; Neil Hyman, MD, FACS; Robert D. Madoff, MD, FACS; Frank J. Opelka, MD, FACS; Bruce A. Orkin, MD, FACS; Russell K. Pearl, MD, FACS; Jan Rakinic, MD, FACS; Theodore J. Saclarides, MD, FACS; Clifford L. Simmang, MD, FACS; Judith L. Trudel, MD, FACS; and Richard Whelan, MD, FACS.

## **Examination committee activities**

The leadership of the examination and recertification committee changed with the September 2000 meeting. With Dr. Rothenberger's de-

parture, Dr. Fleshman, the board's former recertification chair, was elected to serve as the new examination committee chair, and Dr. Hooks was elected the new recertification committee chair.

Under the direction of Dr. Rothenberger, the board's examination pool was reviewed and updated. Obsolete questions were discarded, and remaining questions were forwarded to a medical editor for evaluation. All the questions are now current and uniformly constructed. Also, with the assistance of the medical editor, a comprehensive instructional manual was developed to assist question writers with the construction of good test questions. This should contribute to the quality and quantity of new questions that are submitted to the board.

The board has attempted to upgrade the writing techniques of its question writers. At its meeting on March 19, 2000, the board agreed to organize a question writers' workshop to be cosponsored by the ABCRS and the American Society of Colon and Rectal Surgeons (ASCRS). Dr. Trudel is organizing the workshop, which is scheduled for the spring of 2001; George Bordage, MD, will be the moderator. Invitations will be extended to ABCRS board members, associate examiners, ASCRS core subjects committee members, and program directors. The board feels this effort will help improve the question-writing skills of ABCRS members and better coordinate the work of ABCRS and ASCRS committees.

In other business, psychometric summaries of the board's written examinations have been conducted since 1997. Each analysis has consistently supported the validity, objectivity, and reliability of the written examination. The 1999 oral examination also was analyzed this year, and the results showed that the board's oral process also is being conducted properly. The summaries assist the examination committee in its validation and review process, and in general, the information substantiates the credibility of the board's written examination process. The validations will be continued

Table 1										
Written Exam—March 18, 2000 (58 candidates)						Oral Exam—September 24, 2000 (65 candidates)				
	#	Fail rates	%	Pass rates	%	#	Fail rates	%	Pass rates	%
Total candidates	58	11/58	19%	47/58	81%	65	16/65	25%	49/65	75%
First-time takers	52	8/52	15	44/52	85	49	10/49	20	39/49	80
Repeat candidates	6	3/6	50	3/6	50	16	6/16	38	10/16	62

Table 2							
Total current diplomates	Male	%	Female	%	All	%	
Active U.S.	967	75.66	81	6.33	1,048	82.00	
Active international	62	4.85	2	0.16	64	5.00	
Retired U.S.	157	12.28	2	0.15	159	12.44	
Retired international	2	0.16	0	0.00	2	0.16	
Status/address unknown	5	0.40	0	0.00	5	0.40	
Total	1,193	93.35%	85	6.65%	1,278*	100%	

\*This figure excludes diplomates who are deceased.

with an analysis of each component (written/oral) performed in alternating years.

### ***Colon and rectal retraining program***

At the September 2000 meeting, the board decided to establish an abbreviated educational retraining program for candidates who were unable to achieve certification after exhausting all available opportunities within the prescribed seven-year period. The current policy is: "A candidate who fails to pass either the written or oral portion of the examination three times (within seven years) may not repeat the examination without satisfactory completion of an approved colon and rectal residency program (one year in duration) and submission of a new application for examination."

Because it is difficult for candidates to reenter a conventional residency training program after several years of hiatus, the board agreed to adopt a policy that will provide a more pragmatic reentry mechanism. Retraining still will be required but for a shorter period of time. Tentatively, the board agreed that the training period will be four months in a pre-approved colon and rectal train-

ing program. The curriculum must conform to Accreditation Council on Graduate Medical Education guidelines. Input from program directors will be essential to the process. Ultimately, they will have to help train, confirm, and document that the candidate successfully completed the prescribed curriculum. A final decision has not been reached regarding whether candidates will be required to retake both parts of the examination (written and oral) or will be able to reenter by taking only the portion of the exam they originally failed.

### ***Operative report database issues***

For several years, the ABCRS has maintained an operative database in which the numbers of cases from graduating residents are compiled annually and entered into 17 grouped categories. The board has endorsed a statistical formula that establishes the minimal number of cases that should be performed in each of the categories. These figures are recalculated each year. A number of reports and tables are generated and provided to program directors to assist them in evaluating their residents' operative performance within their own

program and in comparison to national averages. A "category deficiency table" tracks the inadequate performance of each respective resident within the 17 established categories. Any resident who lacks sufficient numbers in five or more categories is "flagged" for discussion by the board's credentials' committee.

At its March meeting, the board reviewed the 1997-1999 deficiency reports. The combined data showed that the average number in each category does not significantly change from year to year. The data also confirmed that a more objective distribution of cases may reduce the annual deficiencies of some programs. This information was brought to the attention of program directors. They were advised that adjustments may need to be made in redistributing the number of cases among their residents. If there are only a limited number of cases available, there may not be enough procedures for all residents; therefore, the resident allotment for a particular program may require modification.

At the September meeting, the board reviewed an updated report representing four years of operative data (1997-2000). This information confirmed the previous conclusions; hence, the board decided to establish minimum numbers that represent a "reasonable range" within each of the 17 established operative categories. The figures will be presented to program directors and will affect residents beginning training July 1, 2001, to June 30, 2002. Program directors will be advised to review residents' case numbers at different intervals of their training so evaluations of deficiencies can be made before residents complete their training. So far, the information in the deficiency reports has not been used to disqualify residents from entering the certification process; however, in the future, some residents may be rejected.

### **Recertification activities**

The June 24, 2000, recertification examination was held during the ASCRS annual meeting in Boston. In all, 16 diplomates participated; 13 passed and three failed. All candidates received pass/fail results and a categorized performance review. As expected, this year's participation was lower because time-limited certificates were extended to 10 years. Attendance is expected to return to normal levels (approximately 60 candi-

dates) by 2002. The pass/fail results are:

<b>Recertification examination</b>				
<b>June 24, 2000</b>		<b>Pass rates</b>		<b>Fail rates</b>
Overall		13/16	81%	3/16 19%
First-time takers		9/11	82	2/11 18
Repeaters		4/5	80	1/5 20
16 participants - 14 mandatory - 2 voluntary				

The range of scores was: maximum: 90 percent; minimum: 59 percent; average: 80 percent, and passing: 70 percent.

The recertification committee is in the process of incorporating Current Procedural Terminology (CPT) codes into the operative experience form used for recertification and, possibly, the certification process. CPT codes and the corresponding colon and rectal procedures are being verified by committee members. The committee has also established an ad hoc panel to design a tracking database based on selected data derived from the recertification application form, operative log, and other related forms. Discussions have been held to ascertain what information is needed and whether the administrative office can provide the necessary database management. The tracking program developed by the American Board of Surgery, as well as other boards, will be appraised.

The recertification application materials have been simplified. The operative report process has been streamlined, and the lengthy recertification application process has been condensed. Validation of 100 Category I CME credit hours will still be required.

### **Examination results**

The most recent written examination (part I) was given on March 18; 58 candidates were examined. The most recent oral examination (part II) was given September 24; 65 candidates were examined. The pass/fail rates are shown in Table 1 on page 28.

### **Geographic/gender distribution**

As of September 30, 2000, the board has 1,278 diplomates: 1,112 in active practice; 166 retired or otherwise inactive. Table 2 (p. 28) provides the male/female and international distribution of diplomates.



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# American Board of Neurological Surgery

by Steven L Giannotta, MD, FACS, Los Angeles, CA

I am pleased to report on the activities of the American Board of Neurological Surgery (ABNS) during the 1999-2000 year. The following outlines the ABNS's major issues and activities.

## **Resident numbers**

There continue to be 94 neurosurgery training programs in the U.S. The results of the January 2000 resident match program show a total of 335 registrations with 258 rank lists submitted. Of these, 219 individuals were ranked and 134 were matched. Currently, 787 residents are in training in the U.S. Over the last five years, the number of residents completing training has varied between 126 and 141.

## **Examinations**

The ABNS gave the 2000 primary written examination on March 25, 2000, at 100 testing centers. A total of 480 individuals took the exam, 198 for credit towards certification and 282 for self-assessment. The examination consisted of 505 questions centered on seven categories: neuroanatomy, neurobiology, neuropathology, neuroimaging, fundamental clinical skills/critical care, neurology, neurosurgery. The overall failure rate was 15 percent, the lowest in over 20 years.

In November 1999, 74 candidates participated in the oral examination, and 61 passed, for a pass rate of 82 percent. In May 2000, 74 candidates were examined and 60 were certified as diplomates of the ABNS.

## **Subspecialization and fellowships**

The ABNS does not issue subspecialty certificates. However, the Society of Neurological Surgeons is developing a mechanism for certifying subspecialty fellowships within neurological surgery. The endovascular surgical neuroradiology subspecialty program requirements have been developed in conjunction with radiology and neurology boards and subspecialty societies. The Accreditation Council for Graduate Medical Education will revisit the issue at its upcoming meeting.

## **Recertification**

In 1999, the ABNS began issuing time-limited certificates valid for 10 years. One component of the recertification process will be a written examination. A prototype exam has been written and tested with the help of the National Board of Medical Examiners. Plans call for the formal introduction of the examination by 2006 with the first recertification candidates taking the examination and applying for recertification in 2007. Other components of the recertification process include the appropriate number of continuing education credits and a practice data log for the year prior to submission of application. The ABNS has kept abreast of the activities of the American Board of Medical Specialties related to general competencies and maintenance of certification. Neurosurgical training program directors have been urged to consider the general competencies and incorporate them into their own individual training programs.

At the May 2000 meeting, the following surgeons completed their six-year terms: Donald O. Quest, MD, FACS; Eugene S. Flamm, MD, FACS; and M. Peter Heilbrun, MD. New directors elected at the meeting are: William F. Chandler, MD, FACS; A. John Popp, MD, FACS; and John H. Robertson, MD. The new officers of the ABNS are: Steven L. Giannotta, MD, FACS, chair; H. Richard Winn, MD, FACS, vice-chair; and Ralph G. Dacey, Jr., MD, FACS, secretary. Donald P. Becker, MD, FACS, remains the treasurer. The next meeting of the ABNS took place on November 7-10, 2000, in Houston, TX.

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# American Board of Obstetrics and Gynecology

by Robert C. Cefalo, MD, PhD, FACS, Chapel Hill, NC

In the future, these reports will be compiled in January rather than in September. The reason for this change has to do with the timing of the results obtained from the examinations administered by the American Board of Obstetrics and Gynecology (ABOG). Several years ago, the board conducted the written examination on a single date and conducted the oral examination on a single date. Thus, keeping up with the results of an examination administered in one year and reporting them the following year was manageable. However, as the number of examinations has increased from two per year to as many as 17 per year, reporting the results of these examinations has become very confusing when spread over a two-year period. Moreover, the final results of the maintenance of certification examinations are not available until after December 31 each year.

## **Oral examination**

Beginning in 2000, all oral examinations administered by the board will be given in Dallas, TX. For the past several years, the subspecialty examinations have been given every spring in Dallas, TX, at the Westin Galleria Hotel. This same hotel will be the site for the basic oral examination in 2000. The difference will consist of an alternate date format. Specifically, because of its increased size, the oral examination was scheduled to be administered in three separate sessions: November 6-10, 2000, December 4-8, 2000, and January 8-12, 2001. This divided format of three separate sessions will be continued in the future for the administration of the basic oral examination in obstetrics and gynecology.

## **Test center**

ABOG currently is constructing a new test center that will be physically contiguous with the current board office. The test center will be used beginning in 2001 for all oral examinations. Rooms will be designed to accommodate the current format of the oral examination and will be equipped with high-resolution computer screens with at-

tached computer capability so that imaging of current Kodachromes and structured cases will become more easily accessible to the examinees and the examiners, as well as provide a markedly improved image of the clinical condition under discussion. Arrangements are being made with hotels within a six- to eight-block radius of this facility to ensure adequate housing for oral examiners and candidates. The first anticipated use for this facility for oral examinations will be for the subspecialty examinations in the spring of 2001. The specific date of these examinations is April 16-18, 2001.

## **Web site**

The board anticipates that the Web site ([www.abog.org](http://www.abog.org)) will become more widely recognized. The following items are presently available on the Web site: current bulletins (obstetrics and gynecology, subspecialties, and maintenance of certification/voluntary recertification), the dates and sites of future examinations, as well as guides to learning in the various subspecialties of obstetrics and gynecology. Within a short period of time, we expect to be able to upgrade the Web site to be even more user-friendly.

## **Maintenance of certification**

In 1999, ABOG and the American Board of Medical Specialties (ABMS) introduced a new term for their recertification processes—maintenance of certification. This phrase was chosen by both organizations for a variety of reasons, but the most urgent was the recognition that only time-limited certificates will be issued by all ABMS boards after the year 2000. Thus, over the next generation, only time-limited certificates will remain. Until then, however, it is important to recognize and to acknowledge those diplomates who do more than is required of them and diplomates with time-limited certificates who choose to recertify.

ABOG issued its first time-limited certificates in 1986. Since then, the ABOG has used two terms—voluntary recertification and certificate renewal.

Voluntary recertification applies only to those diplomates whose certification occurred before 1986. These individuals do not have time-limited certificates. Such diplomates have certificates with no time constraints. Certificate renewal applies to those diplomates with time-limited certificates (certificates issued from 1986 on).

Maintenance of certification was chosen to encompass both terms. Therefore, "maintenance of certification" means both voluntary recertification and certificate renewal. As diplomates who have no time-limited certificates retire, the term "voluntary" recertification will be phased out and maintenance of certification will replace the term "certificate renewal."

### ***New subspecialty***

In February 2000, Gerson Weiss, MD, president of the ABOG, and Andrew C. Novick, MD, president of the American Board of Urology, announced that the two boards have agreed to jointly sponsor and accredit a new subspecialty in female pelvic medicine and reconstructive surgery. This agreement concluded an intense two-year dialogue between the two boards to ensure that adequate subspecialty training will be available in this area for obstetrician/gynecologists and urologists.

The presidents of the two boards emphasized that there are more than 50 million American women over age 50, and a share of them will ultimately develop varying degrees of incontinence. Presently, incontinence problems constitute the second leading cause of institutionalization in the U.S. The availability of appropriately trained specialists and subspecialists in urology and obstetrics and gynecology will ensure that the women of this country will receive appropriate diagnostic evaluation and effective medical and surgical therapy to correct these difficulties. Enhanced access to care for incontinence will improve the quality of life for women experiencing this problem and will result in appreciable savings in health care dollars.

Both Drs. Weiss and Novick stressed the importance of the development of this subspecialty, not only to ensure that these physicians will be able to provide this care, but to ensure that the first wave of such well-trained surgeons also will serve as teachers for other urologists and obstetrician/gynecologists. This will ensure an adequate number of appropriately trained indi-

viduals will be available to meet this increasing need on the part of American women.

The names of the individuals assigned to this new subspecialty are: Dr. Stenchever, director and representative; Dr. Fowler; Nicolette S. Horbach, MD; Edward J. McGuire, MD, FACS; Robert M. Weiss, MD, FACS; and Philippe E. Zimmern, MD, FACS.

### ***Certification: Principal examinations in obstetrics and gynecology***

#### **A. Principal oral examination, November 16-20, 1998, in Chicago, IL**

##### **1. Status of candidates**

Disapproved ad hoc	15
Disapproved—case list	63
Incomplete—no fee	98
No show	4
Result voided	0
Withdrew from exam	32
Took exam	<u>1,474</u>
Total	1,686

##### **2. Pass-fail results**

	<u>Passed</u>		<u>Failed</u>	
	#	%	#	%
Took exam	1,220	83	254	17
U.S. graduates	1,139	84	209	16
International graduates	81	64	45	36
U.S. graduates—				
First-time takers	1,007	86	163	14

#### **B. Principal written examination, June 28, 1999, at multiple sites**

##### **1. Status of candidates**

Applied	1,860
New applicants	1,246
U.S. medical graduates	1,165
International medical graduates	81
Reapplications	614
U.S. medical graduates	388
International medical graduates	226



## 2. Pass-fail results

	Passed		Failed	
	#	%	#	%
Took exam	1,322	78	381	22
U.S. medical graduates	1,224	83	244	17
International medical graduates	98	42	137	58
First-time takers	1,139	92	105	8
U.S. medical graduates—				
First-time takers	1,068	92	97	8
Reapplications	183	40	276	60

## C. Principal oral examination, November 8-12, 1999, in Chicago, IL

### 1. Status of candidates

Disapproved ad hoc	19
Disapproved—case list	29
Incomplete—no fee	75
No show	7
Result voided	0
Withdrew from exam	39
Took exam	<u>1,515</u>
Total	1,684

### 2. Pass-fail results

	Passed		Failed	
	#	%	#	%
Took exam	1,291	85	224	15
U.S. graduates	1,199	93	96	7
International graduates	92	42	128	58
U.S. graduates—				
first-time takers	1,052	96	45	4
Active diplomates—31,812 (approximate)				

The number of candidates taking the 1994 examination was 1,375, and the 1995 number was 1,348. The number in 1996 was 1,441, and the number in 1997 was 1,431. The numbers for 1998 and 1999 were 1,474 and 1,515, respectively. Thus, the number of candidates taking the oral examination appears to have increased the past two years.

## D. Examination trends

1. The pass rates for the principal written examination in obstetrics and gynecology have remained in a very narrow range for the last 10 years. For U.S. graduates of American medical schools, the pass rate has ranged between 87 and 95. For the entire examination, the pass rate has ranged between 66 and 76.

2. The 1990-1999 pass rates for all candidates for the principal oral examination in obstetrics and gynecology are listed below by year. A very narrow range of 83-87 has existed for the last decade. Mode of practice continues to be the major reason for failure on this examination.

1990	85%	1995	84%
1991	83	1996	83
1992	86	1997	84
1993	87	1998	83
1994	87	1999	85

## Maintenance of certification

### A. Certificate renewal/voluntary recertification written examinations

1. Examinations administered on February 28, 1999, in multiple sites

	Passed		Failed	
	#	%	#	%
a. Obstetrics and gynecology				
1. Certificate renewal	196	97	7	3
2. Voluntary recertification	17	94	1	6
b. Obstetrics and gynecology+ gynecologic oncology				
1. Certificate renewal	8	100	0	0
2. Voluntary recertification	2	67	1	33
c. Obstetrics and gynecology+ MFM				
1. Certificate renewal	14	100	0	0
2. Voluntary recertification	—	—	—	—
d. Obstetrics and gynecology+ REI				
1. Certificate renewal	15	100	0	0
2. Voluntary recertification	2	100	0	0

2. Obstetrics and gynecology maintenance of certification examination administered on August 9, 1999, in Dallas, TX

	<u>Passed</u>		<u>Failed</u>	
	#	%	#	%
a. Certificate renewal	82	98	2	2
b. Voluntary recertification	7	100	0	0

3. Pass rates for the combined February and August examinations in obstetrics and gynecology were:

	<u>Passed</u>		<u>Failed</u>	
	#	%	#	%
a. Certificate renewal	278	97	9	3
b. Voluntary recertification	24	96	1	4

## B. Annual board certification (ABC): Certificate renewal and voluntary recertification for 1998

1. For 1998, only the principal discipline in obstetrics and gynecology was offered.

2. There were 4,098 applications received, and of these, 3,995 (97%) were approved.

3. The process was completed by 2,809 (70%) of the 3,995 diplomates approved to participate.

4. Of those diplomates completing the process, 2,791 (99%) passed and 18 (1%) failed.

5. Among the 2,791 diplomates who passed the ABC process, 2,070 (74%) were voluntarily recertified; and 721 (26%) achieved certificate renewal.

## C. ABC: Certificate renewal and voluntary recertification for 1999

1. In 1999, the ABC process was expanded to include basic obstetrics and gynecology plus gynecologic oncology, maternal-fetal medicine or reproductive endocrinology/infertility, as well as basic obstetrics and gynecology.

2. Applications:

	<u>Applied</u>	<u>Approved</u>	<u>Disap- proved</u>	<u>With- drew</u>	<u>Did not complete</u>	<u>Process</u>
	#	#	#	#	#	%
OB/GYN	3,292	3,286	6	17	360	11
ONC	148	148	0	0	44	30
MFM	372	372	0	0	71	19
REI	<u>166</u>	<u>166</u>	<u>0</u>	<u>0</u>	<u>43</u>	<u>26</u>
Totals	3,978	3,972	6	17	518	13

3. Pass-fail numbers and percentages of approved diplomates who started the ABC process.

	<u>Entering</u>	<u>Pass</u>		<u>Did not complete or failed</u>	
	#	#	%	#	%
OB/GYN	3,269	2,895	89	374	11
ONC	148	102	69	46	31
MFM	372	295	79	77	21
REI	<u>166</u>	<u>123</u>	<u>74</u>	<u>43</u>	<u>26</u>
Totals	3,955	3,415	86	540	14

4. Pass-fail numbers and percentages of diplomates who completed the ABC process.

	<u>Entering</u>	<u>Pass</u>		<u>Failed</u>	
	#	#	%	#	%
OB/GYN	2,909	2,895	99	14	1
ONC	104	102	98	2	2
MFM	301	295	98	6	2
REI	<u>123</u>	<u>123</u>	<u>100</u>	<u>0</u>	<u>0</u>
Totals	3,437	3,415	99	22	1

5. Diplomates successfully completing the ABC process either voluntarily or for certificate renewal.

	<u>Voluntary</u>		<u>Certificate renewal</u>	
	#	%	#	%
OB/GYN	2,051	71	844	29
ONC	88	86	14	14
MFM	231	78	64	22
REI	<u>82</u>	<u>67</u>	<u>41</u>	<u>33</u>
Totals	2,452	72	963	28

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### ***Upcoming examinations***

The next principal oral examinations are scheduled for November 6-10, 2000, December 4-8, 2000, and January 3-12, 2001, in Dallas, TX. Subspecialty oral examinations are scheduled for April 16-18, 2001, at the ABOG test center. Written examinations will be held June 25, 2001, at various sites.

The written examination for maintenance of certification is scheduled for February 26, 2001, at various centers and for August 27, 2001, at the ABOG test center. The practice review for maintenance of certification will take place November 6-10, 2000, December 4-8, 2000, and January 3-12, 2001. The ABC certification examination takes place on January 1 of each year.

### ***Officers and board members***

Officers and board members for the year ending on June 30, 2001 are: Gerson Weiss, MD, president; Michael T. Mennuti, MD, vice president; William Droegemueller, MD, director of evaluation; Ronald S. Gibbs, MD, treasurer; Robert Cefalo, MD, PhD, chairman of the board; Haywood L. Brown, MD; Larry J. Copeland, MD, FACS; Alan H. DeCherney, MD; Philip J. DiSaia, MD, FACS; Sherman Elias, MD, FACS; Wesley C. Fowler, Jr., MD, FACS; Larry C. Gilstrap III, MD; Frank W. Ling, MD; Kenneth L. Noller, MD; Valerie M. Parisi, MD, MPH; Nanette F. Santoro, MD; Morton A. Stenchever, MD.

## American Board of Ophthalmology

*by William E. Benson, MD, FACS, Kansas City, MO*

### ***Examinations***

The fall oral examination and meeting of the American Board of Ophthalmology (ABO) was held November 12-14, 1999, in Cambridge, MA. The next annual meeting was scheduled for Friday, November 17, 2000, in San Francisco, CA.

The next written qualifying examination is scheduled for administration on April 20, 2001. Dates and locations for upcoming oral examinations are: November 17-19, 2000, in San Francisco, CA; May 11-13, 2001, in Chicago, IL; October 26-28, 2001, in Cambridge, MA; June 7-9, 2002, in San Francisco, CA; and November 8-10, 2002, in San Francisco, CA.

The total number of diplomates certified at the oral examinations on November 1999 in Cambridge, MA, and on May 2000 in San Francisco, CA, was 517 (236 in Cambridge and 281 in San Francisco). Seventy-nine individuals failed the examination and must repeat all six subjects.

The 2000 written qualifying examination was held on Friday, April 7, at three sites in the U.S. The questions on this examination were prepared by the written examination committee of the ABO and the ophthalmic knowledge assess-

ment program committee of the American Academy of Ophthalmology. The written examination committee reviews and approves the final questions.

Of the 679 registered for the 2000 written qualifying examination (WQE), 623 took the examination, 155 failed (24.8%), and 468 passed. Of the 155 who failed, 77 (49.67%) failed previously. Of the 623 candidates who took the examination, 149 (23.92%) were repeaters; of these, 77 (51.68%) failed again. International medical graduates constituted 7.38 percent (46 candidates) of the examination, and 21 failed (45.65%). U.S./Canadian graduates constituted 92.61 percent (577 candidates), and 134 (23.22%) failed. Of the 149 candidates repeating the WQE, 19 (12.75%) were international medical graduates and 130 (87.24%) were U.S./Canadian graduates.

The candidates who passed the 2000 WQE plus the repeaters from previous oral examinations provide a potential pool of 275 candidates for the November 2000 San Francisco oral examination and 270 potential candidates for the May 2001 Cambridge, MA, oral examination.



### **Recertification**

The next certificate renewal examination, written (CREW) will be offered February 1 through March 31, 2001. (This is a take-home examination for completion in two months.) The next office record reviews (ORRs) will be offered January 1-31, 2001, and July 1-31, 2001 (given twice a year with one month to complete).

The 2000 CREW examination was administered as a take-home examination from February 1 through March 31. Of the 59 registered for this examination, 59 completed the examination; 56 passed (94.92%) and three failed (5.08%).

The ORR was administered July 1 through July 31, 1999, and January 1 through January 31, 2000. All 11 registered at the July 1999 examination completed and passed the review. At the January 2000 examination, 29 were registered, with 28 passing and one incomplete.

### **Representation**

The representative to the American College of Surgeons for 2000 is Lee R. Duffner, MD, FACS, Hollywood, FL. The board's representatives to the residency review committee (RRC) for the year 2000 are: Susan H. Day, MD; Richard P. Mills, MD; and M. Bruce Shields, MD, FACS.

The RRC for ophthalmology, at its June 5-6, 1999, meeting considered 26 agenda items. The following events transpired at this meeting: seven programs received continued full accreditation status, six progress reports were reviewed, 10 administrative decisions were made, one program received voluntary withdrawal status, one probationary accreditation status was granted, and one program received provisional accreditation.

At its December 3-4, 1999, meeting, the RRC for ophthalmology considered 22 agenda items. The results of this meeting are as follows: 14 programs received continued full accreditation status, five progress reports were reviewed, two administrative decisions were made, and one proposed probationary status was given.

### **Officers and board directors**

Following are the officers and board members for 2000: William E. Benson, MD, FACS (chair); John G. Clarkson, MD, (vice-chair); Edward G. Buckley, MD, FACS; and Mark J. Mannis, MD, FACS.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2000 are: Denis M. O'Day, MD, FACS; John G. Clarkson, MD; Richard P. Mills, MD; and Charles P. Wilkinson, MD.

### **General information**

In keeping with the board's principle of continual improvement of both process and examination methods, a more extensive training program was introduced for the associate examiners who participate in the oral examinations. The new system involves a mentoring process that pairs seasoned associate examiners with new examiners, allowing for a detailed instructional orientation, followed by an interactive practice session, and then observation and hands-on training during the oral examination.

For many years the board has required that all individuals who enter an ophthalmology training program complete a general medicine post-graduate clinical year (PGY-1). Occasionally, the board comes across an individual who graduates from an ophthalmology residency without the necessary PGY-1 training. To avoid the resulting disappointment to a resident, the ABO, in August 2000, began to request from program chairs a copy of the PGY-1 certificates for their ophthalmology residents at the PGY-2 level.

The ABO has submitted six subspecialty guidelines (cornea and external disease, glaucoma, neuro-ophthalmology, ophthalmic pathology, pediatric ophthalmology and macula, retina, vitreous) to the RRC for ophthalmology for the Accreditation Council for Graduate Medical Education (ACGME). These documents will now go through the necessary review process.

The ABO is participating in a two-part meeting sponsored by the ABMS and the ACGME. This is a joint initiative on resident evaluation, which is intended to create a plan to improve the assessment of residents during their training and to provide information to member boards for the initial certification process. Each specialty has four representatives, one from each of the following: the board, the RRC, the residency director organization, and the resident pool.

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# American Board of Orthopaedic Surgery

by Robert H. Cofield, MD, Rochester, MN

At the American Board of Orthopaedic Surgery (ABOS), the purposes have remained focused with regard to educational standards and to testing for initial and continuing professional qualifications. The curriculum and corresponding rotational options have been developed for the first postgraduate year to better integrate this period of training within the overall five-year program. Understandably, many programs have accomplished this transition readily, while others have undergone significant alterations. Unlike the first postgraduate year, years two through five have had well-recognized educational objectives, and review of these requirements suggests little change will be necessary over the ensuing few years.

Our two major professional organizations and the Academic Orthopaedic Society continue to provide informational interchange reports with focused presentations to young orthopaedic surgeons and to program directors. There is ongoing interchange with the major professional society to maintain a relationship between educational programming by the society and the testing that occurs, both for certification and for recertification. An initiative has also been developed to further explore the concept of virtual reality in education and testing—initially in the field of arthroscopy.

## ***Credentialing and certification***

Credentialing continues to be a major activity for the board. For recertification, this includes not only the standard credentialing activities, but also a substantive component of peer review, continuing medical education, and a test. Currently, seven tests are available. These include: a written general examination; a computer-administered general examination; a practice-based oral examination; the subspecialty examination in surgery of the hand; and computer-administered examinations that combine general orthopaedic surgery and either sports medicine, surgery of the spine, or adult recon-

struction. Also, we have entered into a pilot project to assess how the traditional outcome measurements might be incorporated into the overall credentialing process.

The initial certification process includes two examinations, a written test and a practice-based oral exam. The written examination is given annually and is formulated with the National Board of Medical Examiners. We have recently reviewed and updated the distribution of questions. We have further studied the standard-setting mechanisms and reviewed the equating activities that are occurring. Ongoing discussions are taking place with regard to converting this test into a computerized test process, as has recently been accomplished with the USMLE. We would envision that this will occur, but its timing is uncertain.

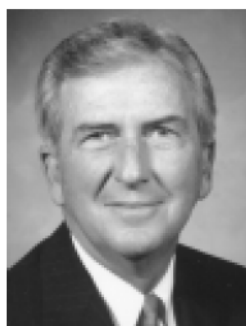
## ***Examinations***

We are fortunate with respect to the oral examination in that images are a large part of orthopaedic surgery. The oral examination is now practice-based with candidates completing and submitting a notarized six-month list of their operative cases. The board then selects cases, which, with supporting documents, constitute the examination materials. Testing what the examinee actually does has great advantages, but it is difficult to score. In this regard, we have had three different psychometricians analyze the examination over time, and there have been a number of suggestions for improving it, including standardization of examiner instructions, increasing the ratio of examiners to examinees, standardizing the scoring process, considering examiner severity as a part of the evaluation process, and developing a criterion standard for passing. All these activities have occurred in a stepwise fashion, and we are confident that the examination will discriminate between those who would meet a standard and those who would not.

*continued on page 57*

# ACS Officers and Regents

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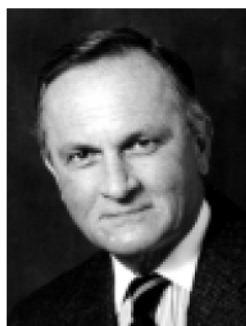


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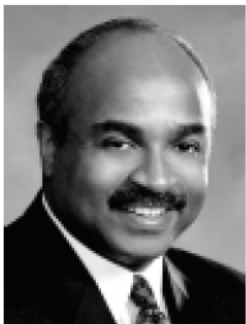


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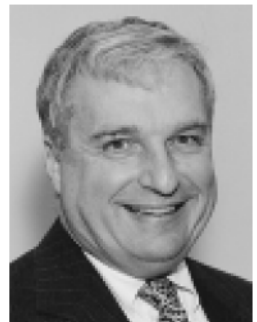
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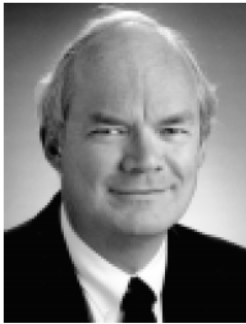
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# CyberSurgeon

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## Virtual reality surgery: Has the future arrived?

by Karen Sandrick, Chicago, IL

As part of the typical surgical routine, surgeons slap X-ray films, computed tomography slices, and even three-dimensional image reconstructions on light boxes along the walls of the operating room so they can step away from the operating table whenever they need to review where a particular structure lies. Is it just beyond the curve of that vessel, just past that turn in the bone, just behind that bit of tissue?

But what if surgeons didn't have to walk away from the table? What if they could view anatomy in three dimensions through stereo video displays in a pair of goggles much like a pair of bifocals? Better yet, what if they could turn the display in any direction or orientation and look at actual three-dimensional images of anatomy superimposed over the operative field from their particular point of view?

Surgeons then would be able to save considerable amounts of time. They wouldn't have to spend an hour with an ultrasound probe double-checking the position of major vessels during liver resection. They would know exactly where to place their ports while performing living-related donor nephrectomy. They could spot a tumor in the adrenal gland without having to interrupt the operation at critical moments to check anatomic images.

"Surgeons would be able to see much more clearly and do things in more efficient and intelligent ways. Knowing exactly what they were going to find and exactly where they were going in and coming out, they would be better able to make all the small decisions of an operation," says Jonathan Silverstein, MD, FACS, assistant professor of surgery and health care informatics at the University of Illinois at Chicago (UIC).

This is the future of virtual reality surgery as Dr. Silverstein sees it, and it's not that far away. Indeed, some elements of virtual reality surgery already are in place at UIC:

Surgical residents are using virtual reality

technology to study the three-dimensional anatomy of the temporal bone, which often is difficult for students to conceptualize even after reviewing textbooks, illustrations, photographs, or cadaveric sections. With the virtual temporal bone, students can see not only the bone itself, they also can rotate it in different orientations and peel off layer after layer of bony

### Tele-immersion technologies

Virtual reality technology is being developed in many clinical and industrial centers throughout the country. The tele-immersion approach, which combines teleconferencing with virtual reality, was invented at the University of Illinois at Chicago Electronic Visualization Laboratory. Researchers there created a portable four-by-six-foot screen called the ImmersaDesk™, which brings computer projections into a viewer's own world. The technology produces stereo vision in a viewer-centered perspective, which means the computer corrects the projected view of a three-dimensional object according to each viewer's position.

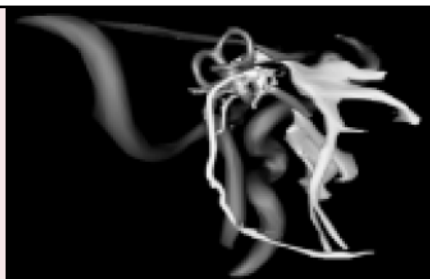
While wearing stereo glasses and using a magnetic hand-tracking device, viewers enter a virtual reality environment that surrounds them with three-dimensional, computerized graphics but does not eliminate their real world. Viewers consequently can see their own hands and talk with other people in the same virtual setting.

"It's not the same virtual environment you see in other areas where you walk into a virtual world and your eyes are covered to the real world. This actually combines the two," explained Jonathan Silverstein, MD, FACS, an assistant professor of surgery and health care informatics at UIC.

As a result, "Teleimmersion or augmented reality will give surgeons the ability to superimpose anatomic images right on their patients while they're operating," he said.

tissue to reveal the semicircular canals, carotid arteries, nerves, and other structures.

A computer model of the virtual pelvic floor is providing colorectal surgery residents with a panoramic view of the muscles of the rectum, coccyx, and anal sphincter from below, the lining of the anal canal, and the network of nerves innervating the pelvis. It is also allowing true three-dimen-



### Temporal bone image

The image pictured above, which appears in color on the cover of this issue, demonstrates the three-dimensional complexity of the internal anatomy of a right temporal bone from the perspective of a person looking down the external auditory canal. The largest structures shown include the facial and trigeminal nerves in yellow, carotid artery in red, venous sinuses and semicircular canals in blue.

The image was created by a multidisciplinary team working with the Virtual Reality in Medicine Laboratory at the University of Illinois at Chicago. Digitized histologic sections were multiplanar reformatted to obtain voxel data at 0.038mm resolution. Each individual structure was then outlined by illustrators on hundreds of images. Finally the three-dimensional structures were regenerated and rendered. The model is used to teach head and neck surgeons.

—Jonathan Silverstein, MD, FACS

This project has been funded in part with federal funds from the National Library of Medicine, National Institutes of Health, under Contract No. N01-LM-9-3543. Dr. Silverstein also acknowledges Berend Hillen, MD, PhD, Utrecht University, for his histologic data and John Stewart, PhD, Medical College of Virginia, for his IsoView software.

sional, stereo surgical teleconferencing. In a virtual pelvic floor broadcast from the UIC Virtual Reality in Medicine Laboratory to two other locations, colorectal surgeons in Chicago, IL, and in Washington, DC, could see and discuss the pelvic floor model from their own perspective.

Ophthalmology residents are testing their ability to manipulate surgical instruments to execute interactive cutting, excision, suctioning, and elevation of tissue. They also learn to manage tearing, drainage, and adhesions while repairing retinal detachments on a virtual reality simulator.

Other applications will soon make virtual reality part of everyday patient care, Dr. Silverstein predicts. The virtual reality laboratory at UIC is working with the department of radiology to transfer three-dimensional radiology data sets to a virtual reality stereo environment for conducting presurgical planning. In a demonstration at the College's 1999 Clinical Congress, Dr. Silverstein's team showed that CT or magnetic resonance imaging data could be manipulated interactively in an immersive environment, instantaneously transforming the view of the data. Features demonstrated included windowing the data from bone to soft tissue and exposing internal structure through the use of cutting planes. With these techniques, the team could identify vessels surrounding a tumor and plot an unobstructed path to the surgical target past vital areas.

In about a year, Dr. Silverstein and his colleagues may start bringing virtual reality into the operating room—at least as a prototype. By then, current large-scale computerized stereo displays may become part of a network that links high-performance computing power with more manageable display units in an operating room; or the displays may be condensed into smaller devices that will not clutter an already crowded surgical suite. These networks and devices are being built in various sites around the country, and when they are integrated into clinical practice, they will add tremendous value and use, Dr. Silverstein says.

Virtual reality simulations will become a standard part of a surgeon's ongoing training, he pre-

*continued on page 63*

**Karen Sandrick** is a freelance medical writer in Chicago, IL.



# Socioeconomic tips of the month

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## Coding for endovascular abdominal aortic aneurysm repair

**C**PT 2001 contains 14 new codes that describe endovascular repair of abdominal aortic aneurysms (AAAs). Endovascular abdominal aortic aneurysm repair is accomplished by placing a carrier, which contains a prosthetic graft, inside the arterial system. Fluoroscopic guidance is used to advance the carrier through the arterial system to the aneurysm. When the aneurysm is reached, the graft is released from the carrier. The graft extends beyond the aneurysm onto normal vessels to create a hemostatic seal.

To accurately report endovascular repair of abdominal aortic aneurysms, several codes are used in combination. Specific codes are used to report the following services: open surgical exposure of the femoral or iliac arteries, insertion of guidewires and catheters, positioning and deployment of the prosthesis, placement of extension cuffs if required, and radiological supervision and interpretation. In addition, there are new codes for placement of an iliac occluding device and for placement of a femoral-femoral bypass graft during endovascular AAA repair. Finally, three new codes have been defined for conversion to open AAA repair, should it be necessary. CPT provides specific coding guidelines and parenthetical notes to help the user identify codes that may be reported in conjunction with one another.

### **Endovascular repair**

CPT codes 34800-34804 are the main ones that describe endovascular repair. The specific code reported is based on the type of prosthesis used (that is, aorto-aortic tube prosthesis, modular bifurcated prosthesis, or unibody bifurcated prosthesis). These codes do not include surgical exposure of arteries (34812, 34820) for the delivery of the prosthesis, nor do they include introduction of catheters into the aorta or selec-

tive catheter placement in aortic branches (36200, 36245-36248); therefore, these services are reported separately.

### **Open arterial exposure**

CPT 34812 and 34820 are new codes that describe open arterial exposure for delivery of the prosthesis. These procedures allow access in the groin or pelvic vessels to insert the device(s), given that current endografts are too large for percutaneous insertion. These codes are reported separately in addition to the primary repair codes.

### **Extension cuffs**

CPT codes 34825 and 34826 describe the placement of a proximal or distal extension cuff when the main prosthesis is too short to reach beyond the aneurysm. It is important to recognize that these codes are reported by vessel, not by the number of extension cuffs placed. If multiple cuffs are placed within the *same* vessel, this service is reported only once. However, if cuffs are placed in two different vessels, code 34825 would be reported for the first vessel, and code 34826 would be used to reflect cuff placement in the second vessel.

### **Unusual repairs**

CPT codes 34808 and 34813 describe adjunctive procedures occasionally performed during placement of an endovascular prosthesis. Code 34808 is defined as endovascular placement of an iliac artery occlusion device, and code 34813 is used to report placement of a femoral-femoral prosthetic graft *during* endovascular AAA repair. Because these are add-on codes and are reported in addition to the other repair codes, they do not require that modifier -51 (multiple procedure) be appended.

### **Conversion to open AAA repair following unsuccessful endovascular repair**

CPT codes 34830-34832 describe the conversion from an unsuccessful endovascular repair to an open aneurysm repair. These codes include dissec-

All specific references to CPT terminology and phraseology are: CPT only © 2000 American Medical Association. All rights reserved.



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tion of the affected vessel, repair of associated arterial trauma, and placement of a traditional graft for repair of the aneurysm.

### **Coding tips**

Radiological supervision and interpretation is reported separately in addition to the endovascular repair series of codes. CPT contains two new codes to report radiological supervision and interpretation, 75952 or 75953. Code 75952 is the primary endovascular supervision and interpretation code; it includes interpretation of the roadmapping arteriogram plus all supervision and interpretation during the routine endovascular AAA repair *except* placement of extension cuffs. Code 75953 is reported for the radiological supervision and interpretation of extension cuffs. Keep in mind, too, that the Health Care Financing Administration does not have regulations limiting payment for radiological supervision and interpretation codes to any particular specialty. A physician who performs radiological supervision and interpretation and completes the necessary documentation should be reimbursed by their carrier for that service.

Although reporting endovascular AAA repair may sound complicated, a five-step "recipe" may be applied for successful coding. First, report the appropriate main endograft repair code (34800, 34802, or 34804). Secondly, report the arterial exposure code (34812 or 34820), recalling that all current devices approved by the Food and Drug Administration require surgical exposure of at least one artery, and frequently bilateral exposure is required. Third, report the introduction of catheters and guidewires, usually 36200, 36245, or other members of that family. Because most devices require guidewire insertion from both femoral arteries, append the modifiers -50 (bilateral procedure) or -59 (distinct procedural service) as needed to accurately describe the procedure. Fourth, report the supervision and interpretation code, usually 75952. Finally, report other ancillary procedures performed, such as extension cuff placement (with its separate supervision and interpretation code 75953), balloon angioplasty (only if performed *outside* of the endograft), stent placement (only if performed *outside* of the endograft), or extensive repair of the artery exposure site.

Additionally, other modifiers may be required to reflect the work of the surgical team performing

the repair. For example, modifier -62 would be appended for co-surgeons (two specialties), while modifier -80 should be used when appropriate to describe an assistant surgeon. The December 2000 issue of the *CPT Assistant* includes more information on reporting endovascular repair of AAA, and it helps clarify the introductory comments in the CPT 2001 book. 

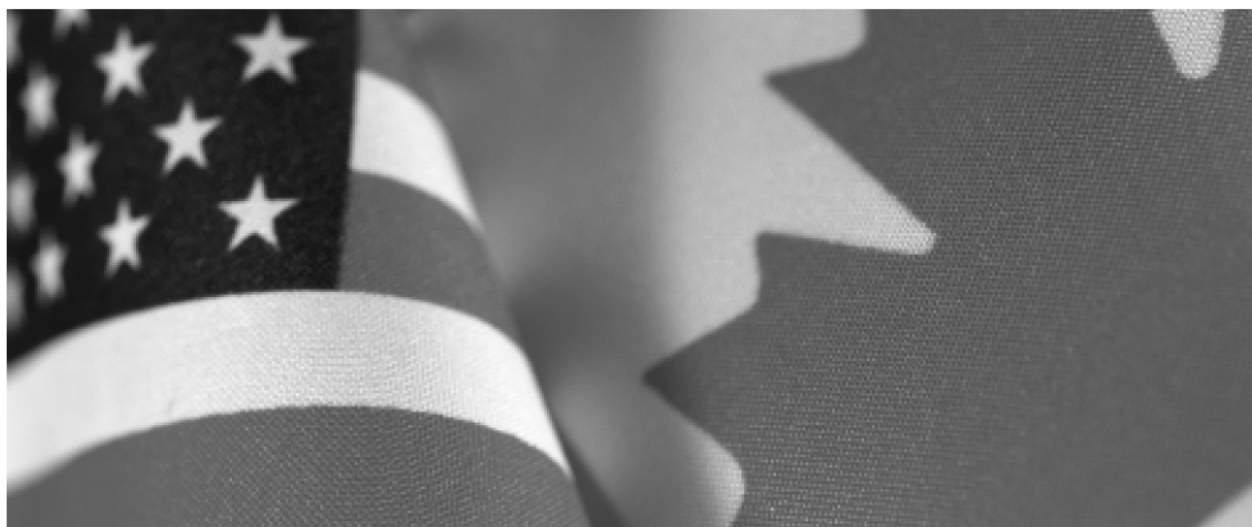
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### **Acknowledgments**

The American College of Surgeons expresses thanks to Robert M. Zwolak, MD, FACS, for his review and comments.

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This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).



April 22-25, 2001

## Toronto to host Spring Meeting

The American College of Surgeons invites you to attend its 29th annual Spring Meeting, which will be held April 22-25, 2001, at the Westin Harbour Castle, Toronto, ON.

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon.

The Advisory Council for General Surgery has planned a program for the 2001 Spring Meeting that will be of interest to all general surgeons. Hands-on postgraduate courses in Image-Guided Breast Biopsy; Breast Ultrasound; Stereotactic Breast Biopsy; Ultrasound for Surgeons; Ultrasound in the Acute Setting; Abdominal Ultrasound: Transabdominal/Intraoperative/Laparoscopic; Ultrasound Instructors' Course; and Surgical Education: Principles and Practice will provide didactic and workshop experience in these techniques, which have become useful and necessary tools for the modern general surgeon.

The Assembly for General Surgeons on Sunday, April 22, will highlight Continued Professional Development: Maintenance of Certification and

will focus on new initiatives of the certifying boards in the U.S. and Canada to replace recertification mechanisms with programs to measure and to maintain professional competence. This interactive general session encourages discussion by all in attendance, so that the views of practicing general surgeons on the important issue of physician accountability to patients, institutions, payors, and regulators can be shared.

Panels on endovascular surgery, misadventures in laparoscopic surgery, inflammatory bowel disease, neoadjuvant therapy for cancer, appendicitis, and new directions in cancer care will be complemented by popular didactic courses in minimal access surgery, vascular surgery, and trauma. The Film Program, Highlights from the 2000 Clinical Congress, will round out an exciting spring program.

To enhance the educational value of this meeting, technical exhibits will again be presented. More than 50 companies will present products or services that relate to the practice of surgery.

Plan to attend the College's 29th Annual Spring Meeting. Information about the scientific program follows.

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## Preliminary Program

*All general sessions take place in the Westin Harbour Castle.*

### General Sessions

#### Sunday, April 22

1:15–1:30 pm

##### Welcome and Opening Remarks

1:30–5:00 pm

Assembly for General Surgeons (GS01)

##### A Town Meeting—Continued Professional Development: Maintenance of Certification

MODERATOR: Roger G. Keith, MD, FACS, *Saskatoon, SK*

Lifelong learning is an expectation of surgical practice. The accountability for maintaining competence has been required of surgeons by licensing authorities, health care organizations, and certifying boards. Methods to validate accreditation for continuing professional development vary throughout the world. In the U.S. and Canada, programs may include mandatory self-accreditation systems and reexamination. Reporting may be voluntary or conditional to licensure or recertification. Presentations will be made by authorities on maintenance of competence from Canada and the U.S. to update current understanding of all aspects of the various programs. An opportunity will be provided for discussion with the panel of experts.

##### Continuing Professional Development: International Developments and Current Programs

John Parboosingh, MB, FRCSC, *Ottawa, ON*

##### Maintenance of Certification: The Royal College Program for Canadian Specialists

Bernard Langer, MD, FACS, *Toronto, ON*

##### Maintenance of Competence: Measuring General Competencies of American Specialists

David L. Nahrwold, MD, FACS, *Chicago, IL*

##### Maintenance of Competence: The View at the American Board of Surgery

Wallace P. Ritchie, MD, FACS, *Philadelphia, PA*

#### Monday, April 23

8:30–10:30 am

General Session (GS02)

##### Endovascular Surgery for Abdominal Aortic Aneurysm

MODERATOR: Christopher K. Zarins, MD, FACS, *Stanford, CA*

##### Overview and Introduction

Christopher K. Zarins, MD, FACS, *Stanford, CA*

##### Endovascular Aortic Aneurysm Repair: Technique, Devices, Patient Selection

Roy K. Greenberg, MD, *Cleveland, OH*

##### Early and Long-Term Results of Endovascular Aneurysm Repair—Will It Replace Open Surgery?

W. Anthony Lee, MD, *Gainesville, FL*

### ACS Advisory Council for General Surgery

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##### STAFF:

Karen S. Guice, MD, FACS, *Chicago, IL*, Director,  
ACS Fellowship Department  
Ellen MacRae Waller, *Chicago, IL*, Committee  
Coordinator



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Early and Long-Term Outcome following Open Surgery—Is It Still the Gold Standard?

Mark F. Fillinger, MD, FACS, *Lebanon, NH*

11:00 am–12:00 noon

Excelsior Surgical Society/Edward D. Churchill Lecture (GS03)

**The Evolution and Current Status of Surgery for Hiatus Hernia and Gastroesophageal Reflux**

INTRODUCER: Paul Friedmann, MD, FACS, *Springfield, MA*

LECTURER: F. Griffith Pearson, MD, FACS, *Mansfield, ON*

This lecture is named for the Excelsior Surgical Society, a group of 80 medical officers who met for the first time in 1945 at the Excelsior Hotel, Rome, Italy. This lecture also honors Colonel Edward D. Churchill, a famous surgeon and consultant to the U.S. Army in the World War II Italian Theater, who presented the first keynote address at this meeting.

1:30–5:00 pm, General Session (GS04)

**Misadventures in Advanced Laparoscopic Surgery**

MODERATOR: Matthew V. Westmoreland, MD, FACS, *Dallas, TX*

Laparoscopic Nissen Fundoplication

J. Barry McKernan, MD, FACS, *Marietta, GA*

Laparoscopic Colon Resection

Morris E. Franklin, Jr., MD, FACS, *San Antonio, TX*

Laparoscopic Adrenalectomy

Lee L. Swanstrom, MD, FACS, *Portland, OR*

Laparoscopic Splenectomy

Ronald J. Aronoff, MD, FACS, *Dallas, TX*

Laparoscopic Gastric Bypass

Alan C. Wittgrove, MD, FACS, *San Diego, CA*

Laparoscopic Heller Myotomy

Matthew V. Westmoreland, MD, FACS, *Dallas, TX*

7:00–9:30 pm, Film Program (GS05)

**Highlights of the 2000 Clinical Congress**

INTRODUCER: Zane Cohen, MD, FACS, *Toronto, ON*

## Tuesday, April 24

8:30–10:30 am, General Session (GS06)

**Inflammatory Bowel Disease**

MODERATOR: Zane Cohen, MD, FACS, *Toronto, ON*

Dysplasia Cancer and IBD: Incidence and Surveillance Strategies

Robert Riddell, MD, *Hamilton, ON*

Role of Laparoscopic Surgery in IBD

Jeffrey W. Milsom, MD, FACS, *New York, NY*

Management of Perianal Crohn's Disease

Ian C. Lavery, MD, FACS, *Cleveland, OH*

Quality of Life following Surgery for Ulcerative Colitis

John H. Pemberton, MD, FACS, *Rochester, MN*

1:30–5:00 pm, General Session (GS07)

**Neoadjuvant Therapy for Cancer**

MODERATOR: Edward M. Copeland III, MD, FACS, *Gainesville, FL*

Neoadjuvant Therapy for Stage III Breast Cancer

V. Suzanne Klimberg, MD, FACS, *Little Rock, AR*

Neoadjuvant Therapy for Rectal Cancer

Scott R. Schell, MD, *Gainesville, FL*

Neoadjuvant Therapy for Soft Tissue Sarcomas

Raphael E. Pollock, MD, FACS, *Houston, TX*

Neoadjuvant Therapy for Upper Aerodigestive Malignancies

Bruce Minsky, MD, *New York, NY*

## Wednesday, April 25

9:00 am–12:00 noon, General Session (GS08)

**Appendicitis: A New Look at an Old Disease**

MODERATOR: J. David Richardson, MD, FACS, *Louisville, KY*

Introduction to Epidemiology of Appendicitis

J. David Richardson, MD, FACS, *Louisville, KY*

Aids to Diagnosis of Appendicitis: When, What, and How Much?

Wayne H. Schwesinger, MD, FACS, *San Antonio, TX*

Appendicitis in Children

Mary Elizabeth Fallat, MD, FACS, *Louisville, KY*

Treatment of Appendicitis: Laparoscopic vs. Open Operation

Carol Scott-Conner, MD, FACS, *Iowa City, IA*

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Strategies for Treatment of Appendicitis: Nonoperative Treatment, Interval Appendectomy, or Standard Operation

Jonathan L. Meakins, MD, FACS, *Montreal, PQ*

Negative Appendectomy Rate vs. High Perforation Rate: What Is the Proper Balance?

Ronald M. Stewart, MD, FACS, *San Antonio, TX*

1:30–4:30 pm, General Session (GS09)

**Current Cancer Care in the Year 2001: Case Management Symposium**

MODERATOR: Cornelius O. Granai, MD, FACS, *Providence, RI*

Case 1—Work-Up and Management of Suspicious Mass in the Neck

Helmuth Goepfert, MD, FACS, *Houston, TX*

Case 2—Diagnostic Work-Up and Management of Coin Lesion in the Lung

William H. Warren, MD, FACS, *Chicago, IL*

Case 3—Management of High-Risk Breast Cancer Patient

William C. Wood, MD, FACS, *Atlanta, GA*

Case 4—Management of Rectal Cancer

David J. Schoetz, Jr., MD, FACS, *Burlington, MA*

Case 5—Prostate Cancer: Radiation Therapy vs. Radical Surgery

Adam S. Kibel, MD, *St. Louis, MO*

Case 6—Management of Pelvic Mass (Gynecologic)

James W. Orr, Jr., MD, FACS, *Ft. Meyers, FL*

## Postgraduate Courses

*All postgraduate courses take place in the Westin Harbour Castle.*

**Postgraduate Course 1—Image-Guided Breast Biopsy (Core Lectures)**

Sunday, April 22, 7:30 am–12:00 noon  
4 hours; fee: \$250

CHAIR: Philip Z. Israel, MD, FACS, *Marietta, GA*

The objective of this course is to teach surgeons how to identify mammographic abnormalities and recognize when to order additional image studies. Surgeons will learn how to differentiate between benign and

malignant lesions and when to recommend close follow-up as opposed to operation. Surgeons will learn how to correlate the mammographic image with the pathologic finding and to implement appropriate clinical pathways. The technique for the performance of stereotactic biopsy and ultrasound guided biopsy will be reviewed.

## Postgraduate Course 2—Surgical Education: Principles and Practice

Sunday, April 22, 8:30 am–12:30 pm and 2:00–5:00 pm  
6 hours (2 sessions); fee: \$350

CO-CHAIRS: Col. Mary E. Maniscalco-Theberge, MD, FACS, *Reston, VA*

Michael R. Marohn, DO, FACS, *Alexandria, VA*

The objective of this course is to enhance the teaching skills of surgeons active in student and/or resident teaching. The principles of adult learning, needs assessment, questioning and feedback skills, and performance evaluation will be reviewed. In addition, the participants will develop a thorough understanding of the practical applications of these principles, both in and out of the operating room.

## Postgraduate Course 3—Ultrasound for Surgeons

Sunday, April 22, 1:00–5:30 pm  
4 hours; fee: \$500

CHAIR: R. Stephen Smith, MD, FACS, *Wichita, KS*

The objective of this course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. The basic core module or its equivalent is a prerequisite for education in advanced training modules in the management of specific clinical problems.

The basic course is an introduction to ultrasound and does not qualify the surgeon to apply the technique independently. Successful completion of a focused module(s) will make the participant eligible for verification by the College, implying that the surgeon is "proctor-ready." (*Limited seating.*)

## Postgraduate Course 4—Breast Ultrasound

Monday, April 23, 8:30 am–12:00 noon and 1:00–5:00 pm  
7 hours (2 sessions); fee: \$500

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CHAIR: Edgar D. Staren, MD, PhD, FACS, *Toledo, OH*

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live model and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

*Prerequisite:* Ultrasound for Surgeons (PG 3). If you have not taken the ACS-sponsored prerequisites but have taken a comparable course elsewhere, please provide the following along with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty. (*Limited seating.*)

### **Postgraduate Course 5— Minimal Access Surgery**

Monday, April 23, 8:30 am–12:00 noon and 1:30–5:00 pm  
6 hours (2 sessions); fee: \$400

CHAIR: Myriam J. Curet, MD, FACS, *Stanford, CA*

The objective of this course is to provide the general surgeon with an overview of established and emerging minimal access surgery techniques. Topics include well-known procedures such as hernia repair, fundoplication, and appendectomy. Procedures that are currently becoming mainstream, such as laparoscopic ventral hernia repairs and laparoscopic treatment of morbid obesity, will be discussed. Less common applications will also be covered, including enteral access, reoperative laparoscopic surgery, and esophagectomy. Finally, newer applications in pediatric surgery, thoracic surgery, minimal access breast surgery, and robotics will be addressed.

### **Postgraduate Course 6— Ultrasound Instructors' Course**

Monday, April 23, 7:30 am–12:00 noon  
4 hours; fee to be announced

CHAIR: M. Margaret Knudson, MD, FACS, *San Francisco, CA*



The Ultrasound Instructor Course is designed to provide the experienced surgeon sonographer with the skills necessary to teach ultrasound to surgical residents at the local level and to practicing surgeons at the national level.

*Prerequisite:* Approval by National Ultrasound Faculty Vice-Chair for Education. Contact Phaedra White at [pwhite@facs.org](mailto:pwhite@facs.org) for additional information.

### **Postgraduate Course 7— Ultrasound in the Acute Setting**

Monday, April 23, 12:30–6:30 pm  
6 hours (2 sessions); fee: \$750

CHAIR: Heidi L. Frankel, MD, FACS, *Milford, CT*

The objective is to familiarize the participant with areas of ultrasound frequently used by general surgeons



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to evaluate patients with acute surgical problems. The participant will learn focused ultrasound examinations through individual hands-on experience and will acquire an understanding of the essentials of ultrasound technology and physics.

*Prerequisite:* Ultrasound for Surgeons (PG 3). If you have not taken the ACS-sponsored prerequisites but have taken a comparable course elsewhere, please provide the following along with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty. (*Limited seating.*)

### **Postgraduate Course 8— Abdominal Ultrasound: Transabdominal/ Intraoperative/Laparoscopic**

Tuesday, April 24, 7:30 am–12:00 noon and 1:00–5:00 pm; Wednesday, April 25, 7:30 am–12:00 noon  
12 hours (3 sessions); fee: \$1,000

CHAIR: Junji Machi, MD, PhD, FACS, *Honolulu, HI*

The objective of this course is to provide the practicing surgeon and surgical resident with advanced education and training in abdominal ultrasound, including transabdominal, intraoperative, and laparoscopic ultrasound as it is used in the diagnosis and treatment of abdominal diseases. This one-and-a-half-day course will consist of lectures and individual hands-on sessions. Human model, live animal, excised liver, and phantom will be used to develop skills in abdominal ultrasound imaging and ultrasound-guided procedure.

*Prerequisite:* Ultrasound for Surgeons (PG 3). If you have not taken the ACS-sponsored prerequisite but have taken a comparable course elsewhere, please provide the following along with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty. (*Limited seating.*)

### **Postgraduate Course 9— Vascular Surgery 2001**

Tuesday, April 24, 8:30 am–12:00 noon and 1:30–5:00 pm  
6 hours (2 sessions); fee: \$300

CHAIR: Douglas L. Wooster, MD, FACS, *Toronto, ON*

The objective of this course is to provide an update on challenging and controversial issues in vascular management. The participants will be provided with evidence-based approaches using recent study and practice guideline data wherever possible.

### **Postgraduate Course 10— Stereotactic Breast Biopsy**

Wednesday, April 25, 7:30 am–12:00 noon and 1:00–5:30 pm  
8 hours (2 sessions); fee: \$450

CHAIR: Darius Francescatti, MD, FACS, *Chicago, IL*

The objective of this course is to introduce the surgeon to the principles and practice of stereotactic biopsy as a minimal access means of obtaining tissue samples for diagnosing indeterminate suspicious mammographic lesions. An overview of radiation safety issues as related to stereotaxis, as well as the technical efficacy and cost analysis of stereotactic versus other alternatives, will be presented.

*Prerequisite:* Image-Guided Breast Biopsy (PG 1). If you have not taken the ACS-sponsored prerequisite but have taken a comparable course elsewhere, please provide the following along with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty. (*Limited seating.*)

### **Postgraduate Course 11—Early Diagnostic Dilemmas in the Trauma Patient**

Program unavailable at press time. Please consult the ACS Web site for more detailed information.

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**The Spring Meeting will conclude at 5:30 pm  
on Wednesday, April 25, 2001.**

The American College of Surgeons sponsors this conference to promote advances in surgery and other areas of science. The information presented through the programs and exhibits is not verified or endorsed by the American College of Surgeons. Presenters and exhibitors are solely responsible for content.



## Registration procedure

*Note: The official registration form for the Spring Meeting may be found online, duplicated/filled out, and submitted:*

**Online**—Internet access [www.facs.org](http://www.facs.org). Visa, MasterCard, or American Express payment of registration and postgraduate course fees must be included on your registration form.

**By fax**—When you pay by credit card, you may complete the registration form and fax to 800/682-0252. Visa, MasterCard, or American Express payment of registration and postgraduate course fees must be included on your registration form.

**By mail**—Complete and mail the registration form to: American College of Surgeons, P.O. Box 92340, Chicago, IL 60675-2340. Payment of registration and postgraduate course fees must accompany your registration form. Visa, MasterCard, or American Express payment will be accepted.

Prior to the meeting, each advance registrant will receive a name badge, attendance verification card, postgraduate course ticket(s), and syllabus(i), if applicable. Therefore, you will have an opportunity to review the postgraduate syllabus before the Spring Meeting. Free replacement syllabi will not be issued.

International and Canadian registrants will not receive postgraduate course syllabus(i) in advance, but can obtain a syllabus by presenting the course ticket at the registration area in the Westin Harbour Castle.

If you are unable to register in advance, bring the completed registration form with the proper credentials and payment to the on-site registration desk in the Westin Harbour Castle.

### **On-site registration hours**

Sunday, April 22 .....	7:00 am–5:30 pm
Monday, April 23 .....	7:00 am–7:00 pm
Tuesday, April 24 .....	7:00 am–5:00 pm
Wednesday, April 25 .....	7:00 am–12:00 noon

### **Registration fees/credentials**

Please note the various registration fees and credentials required for processing your registration.

After March 12:

Fellow

Current white ID card ..... No fee

Associate Fellow

Current yellow ID card ..... No fee

Candidate Group participant

Blue endorsement card ..... No fee

Guest Physician

Medical identification ..... \$425

Resident in surgery

Letter signed by chief of surgery  
(preferred) or hospital administrator ..... \$125

Medical student

Letter signed by appropriate medical  
director ..... No fee

PhD

Business card ..... \$425

Allied health professional

Medical identification ..... \$200

Commercial press

Business card ..... \$175

Commercial representative

Business card ..... \$425

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### ***Postgraduate courses/fees***

Course tickets may only be purchased by registered meeting attendees. Each course requires a ticket for admission. Tickets may only be exchanged before the beginning of a course. Please note that for Postgraduate Courses 4, 6, 7, 8, and 10, a prerequisite is required.

### ***Technical exhibits***

To enhance the educational value of the meeting, more than 50 companies will display products or services that relate to the practice of surgery. Registration includes a reception on Monday, April 23, 5:00 to 7:00 pm, in the exhibit area. Technical exhibits will be open on Monday, from 12:00 noon to 3:30 pm and from 5:00 to 7:00 pm; and on Tuesday, from 10:00 am to 3:30 pm.

### ***Accreditation***

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

### ***CME credit***

The American College of Surgeons designates this educational activity for a maximum of 38 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

### ***Hotel reservations***

A block of rooms has been reserved at the Westin Harbour Castle for ACS Spring Meeting participants. To make your reservation, call the hotel directly and identify yourself as an ACS meeting participant.

Westin Harbour Castle  
1 Harbour Square  
Toronto, ON, M5J 1A6  
416/869-1600  
1/800-WESTIN-1  
(Central reservations, Canada and U.S.)  
Fax: 416/361-7448; [www.westin.com](http://www.westin.com)

Single: \$161.00 (Canadian)  
Double: \$161.00 (Canadian)

The deadline for hotel reservations is Monday, March 19, 2001. After that date, the ACS convention rate will no longer be in effect, and the hotel may charge its regular rates, subject to availability.

### ***Transportation***

As an ACS meeting participant, you can save on round-trip fare by flying United, Delta, or Air Canada:

### ***United Airlines***

1-800/521-4041  
7:00 am–12:00 midnight (ET)  
ACS File 597YR

### ***Delta Air Lines***

1-800/241-6760  
8:30 am–11:00 pm (ET)  
ACS File 170484A

### ***Air Canada***

1-800/361-7585  
8:00 am–8:00 pm (ET)  
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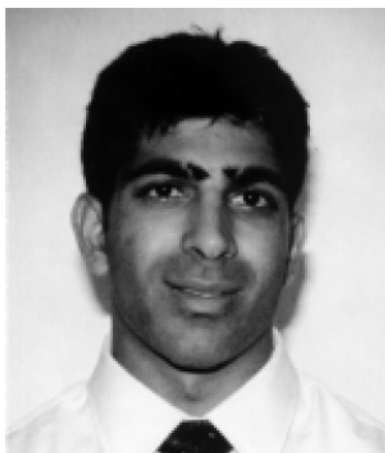
## Research scholarships and award for 2001 granted

Six American College of Surgeons Resident Research Scholarships for 2001 were awarded by the Board of Regents in October 2000. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of \$30,000 for each of two years, beginning July 1, 2001. The recipients are:

**Gorav Ailawadi, MD**, resident in surgery, University of Michigan, Ann Arbor. Research project: The effect of nitric oxide on matrix metalloproteinase production in aneurysm formation. Dr. Ailawadi's research will be conducted at the University of Michigan Medical Center, Ann Arbor. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

**Kelli R. Brooks, MD**, resident in surgery, Duke University, Durham, NC. Research project: Prevalence and prognostic relevance of aberrant promoter hypermethylation of the adenomatous polyposis coli gene in non-small cell lung carcinoma. Dr. Brooks' research will be conducted at Duke University Medical Center, Durham, NC. The scholarship is funded by the Scholarship Endowment Fund of the College.

**John V. Flannery, Jr., MD**, resident in surgery, University of North Carolina, Chapel Hill. Research project: Inhibition of the transcription factor NF-



Dr. Ailawadi



Dr. Brooks



Dr. Johnston



Dr. Louie

Kappa B to promote sensitivity of pancreatic cancer to gemcitabine. Dr. Flannery's research will be conducted at Massachusetts General Hospi-

tal, Boston, MA. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

**Douglas R. Johnston, MD**, resident in surgery, Harvard



Dr. Flannery

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Dr. Si

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University (Massachusetts General Hospital), Boston, MA. Research project: The roles of costimulatory molecules in the pathogenesis and

treatment of chronic lung allograft rejection in MHC inbred miniature swine. Dr. Johnston's research will be conducted at Massachusetts General Hospital, Boston, MA. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

**Otway Louie, MD**, resident in surgery, Cornell University-New York Presbyterian Hospital, New York, NY. Research project: Inhibition of intimal hyperplasia by denoviral-mediated overexpression of SMAD7. Dr. Louie's research will be conducted at New York Presbyterian Hospital, New York, NY. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

**Ming-Sing Si, MD**, resident in surgery, University of California, Irvine. Research project: Disrupting the immunological synapse for therapeutic immunomodulation and immunotolerance in organ transplantation. Dr. Si's research will be conducted at Stanford University, Stanford, CA. The scholarship is sponsored by Ethicon, Inc.

The George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award for 2001 was granted to **Matthias G. Stelzner, MD, FACS**, assistant professor of surgery, University of Washington, Seattle, for his research project on ileal stem cell transplantation in dogs. The purpose of the



Dr. Stelzner

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award is to provide five years of support for promising young surgical investigators. The scholarship is sponsored by The Clowes Fund, Inc., of Indianapolis, IN, in the amount of \$40,000 each of the five years, beginning July 1, 2001.

Further information regarding the scholarships, fellowships, and awards offered by the College for 2002 was published in the January *Bulletin* and appears on the College's Web site, [www.facs.org](http://www.facs.org).

# The ACS coding hotline has answered more than 100,000 coding questions.

## Have you taken advantage of this membership service?

The College's coding hotline—800/ACS-7911 (800/227-7911)—was established over five years ago to provide Fellows with immediate access to coding specialists specifically trained in procedural coding for your specialty. These specialists have direct access to a dynamic database organized by procedural code, payor, and state. The database is updated on a regular basis.

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Since the hotline's inception, calls have increased from 15 per day to more than 50 per day. Because of this growth and in order to continue the quality of service you have received in the past, it has become necessary to adopt stricter guidelines for hotline usage as follows:

■ Confirmation of ACS Fellowship is required to obtain Hotline assistance. The Hotline staff will ask that Fellows give their Fellowship identification number when calling the Hotline. Hotline services are provided and measured in Consultation Units (CUs.) One CU is a period of up to 10 minutes with additional 10-minute increments or portions thereof charged at one CU per 10-minute increment. Hotline services are limited to two CUs for each tele-

phone call. Calls over 20 minutes may require private consultation. Each caller will be advised of appropriate consultation fees to conduct said review (i.e., reviewing operative notes, etc.).

■ ACS Fellows are given 10 consultation units (CUs) in one 12-month period. Unused consultations will not roll over into the next 12-month period. Additional CUs are available for purchase by Fellows at the prevailing

Physician Reimbursement Systems (PRS) retail price (\$230 per 10 additional units through June 31, 2001). Operative notes are not eligible for ACS Hotline services. Coded operative notes will only be reviewed using individually purchased CUs at the prevailing PRS retail price.

■ The hours of operation are from 7:00 am to 4:00 pm (MT), Monday through Friday, holidays excluded.



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## 2001 International Guest Scholars selected

During the 2000 Clinical Congress in Chicago, IL, the ACS International Relations Committee selected eight young scholars as the 2001 International Guest Scholarship awardees.

The scholars are: **Farhat Abbas, MD**, Karachi, Pakistan; **Noel Ernesto Corrales V., MD**, Guatemala, Guatemala; **Alun Huw Davies, BCh, DM**,

FRCS(Eng), London, England (Abdol Islami Scholar); **Emanuel R. Ezeome, MD**, Enugu, Nigeria; **Mehmet Ayhan Kuzu, MD**, Ankhar, Turkey; **Juan Carlos Meneu-Diaz, MD**, Madrid, Spain; **Maria Virginia Rodriguez Funes, MD**, San Salvador, El Salvador; and **Diego Luis Sinagra, MD**, Buenos Aires, Argentina.

The College offers Interna-

tional Guest Scholarships each year to competent young surgeons who have demonstrated strong interests in teaching and research. The scholarships in the amount of \$10,000 each, offer the opportunity for individuals to visit clinical, teaching, and research activities in North America and to attend the ACS Clinical Congress in October.

## AWS Foundation announces Visiting Professor Program

The Association of Women Surgeons (AWS) Foundation has issued a call for applications for its Visiting Professor Program, a new initiative being launched by the foundation. Applications are being sought for both visiting professors and host sites. The visiting professor will participate in a two-day program

that may involve lectures, discussion groups, patient evaluation, patient rounds, and operative procedures and will afford the professor the opportunity to interact with local women surgical faculty, residents, and medical students. The host site will ensure that the department of surgery at the institution will

sponsor the program and arrange all details associated with the visit.


For further information on this program and for application forms, contact the AWS at 414 Plaza Dr., Ste. 209, Westmont, IL 60559; tel. 630/655-0392, or visit <http://womensurgeons.org/visprofprgm.htm>.

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## ORTHOPAEDIC SURGERY, from page 37

The only subspecialty examination is the certificate of added qualifications (CAQ) in hand surgery administered through the joint committee for surgery of the hand and done in conjunction with the American Board of Surgery and the American Board of Plastic Surgery.

In spite of using criterion standards for success on the examinations, the passing rates have remained fairly constant over time. In 1999, 80 percent of the total examinees passed the part I examination, with 90 percent of U.S. and Canadian first-time examinees passing. In 1999, 90

percent of the passing examinees had previously passed both parts of the certifying examination. Of those taking additional fellowship training in surgery of the hand, 100 percent taking the CAQ examination passed. Of those being examined for recertification, 98 percent passed when all pathways were considered. Six of the pathways had similar passing rates with the oral recertification mechanism having a somewhat lower passing rate. In 1999, 623 individuals became certified by the ABOS, with this number remaining relatively stable over the last five years. 

American College of Surgeons

## CAREER OPPORTUNITIES POSITION AND RESUME DATA BANK NOW ONLINE

A Career Opportunities Position and Resume Data Bank is now online on the American College of Surgeons' Web site at <http://web.facs.org/jobs/toc.htm>. The data bank is available to Fellows and resident and young surgeon members of the Candidate and Associate Society (CAS-ACS) and is being provided at no cost. It provides Fellows with a location for listing employment and fellowship openings, and with the ability to search a list of surgeons seeking employment or practice opportunities. CAS-ACS members seeking employment or fellowships can post their resumes and interests at no cost and can access the employment opportunity listings. All that is needed to use the data bank is an ACS membership identification number. For more information about this service or the CAS-ACS, contact Susan Grunwald at the ACS via e-mail at [sgrunwald@facs.org](mailto:sgrunwald@facs.org) or tel. 312/202-5231.

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## College adds legislative action center to Web site

Fellows now have a new tool for contacting members of Congress on issues of concern to them. The ACS Health Policy and Advocacy Department's "Legislative Action Center" can now be accessed online at <http://congress.nw.acs.org>.

[us/facs/](http://us/facs/). This service allows Fellows to find information about members of their state's congressional delegation and other legislators on Capitol Hill, key issues that the College is tracking in Congress, and the College's latest

legislative alerts. This initiative is part of an ongoing effort to increase grassroots advocacy among the Fellowship. For more information, contact Christopher Gallagher via e-mail at [cgallagher@facs.org](mailto:cgallagher@facs.org).

## Update your information online

The College has developed a program through which Fellows can update and edit their individual listings (including addresses, telephone and fax numbers, and e-mail addresses).

Please visit the College's Web site at <http://www.facs.org> and click "Submit Revisions to Database Listing." Fellows will need their eight-digit identification number to input the infor-

mation. Once you have entered the information, your Fellowship record in the College membership database will automatically be updated. There is no need to notify the College offices.

## NIH course on human research protections goes online

A new continuing education program entitled "Human Participant Protections Education for Research Teams" is now available online at <http://cme.nci.nih.gov>. Developed by the National Cancer Institute for the National Institutes of Health (NIH), the Web-based course offers continuing medical education credit for physicians and contact hours for nurses and other members of research teams. The program responds to the mandate requiring education on human subjects protection for all investigators who apply for or receive NIH funds for research involving people.

The course incorporates interactive modules, case studies, and

exercises, and covers, among other topics: roles and responsibilities of researchers and their key personnel; guiding ethical principles for research; federal regulations; informed consent; data and safety monitoring; reporting of adverse events; and privacy and confidentiality. The program offers up to two hours of category 1 credit of the Physicians Recognition Award of the American Medical Association. Cine-Med, a continuing medical education provider, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor the credits. Application for nursing contact hours is in progress.

### Correction

There was a typographical error in the article, "CPT changes in 2001," that appeared in the January 2001 issue of the *Bulletin* (p. 15). The code number for the image-guided placement of a metallic localization clip should be 19295. The code number that appeared—19125—is for the subsequent excision of single breast lesion identified by a previously placed radiologic marker, and code number 19126 is for the excision of each additional lesion. The editors regret any confusion the error may have caused.



# GUIDELINES

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## AMBULATORY SURGERY GUIDELINES UPDATED...

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### Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery

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*Third edition*



Developed by the American College of Surgeons' Board of Governors' Committee on Ambulatory Surgical Care, the guidelines are intended to help surgeons who perform surgical procedures in their offices ensure that they provide those services in an appropriate manner and safe environment.

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*Available from:* Publications Fulfillment, ACS, 633 N. Saint Clair St., Chicago, IL 60611. Single copies: free, two or more copies: \$5.00 each; 10 or more copies: \$4.50 each.

## \$2 million grant awarded for technology education program

The Philadelphia Health Care Trust recently awarded a \$2 million grant to the Foundation for Advanced Medical Education (FAME), which, with the help of the American College of Surgeons, is developing a model program to teach physicians about the safe and effective use of new technology and procedures. Based in Philadelphia, PA, FAME is a division of the American

Medical Foundation for Peer Review and Education. Several specialty societies also are collaborating on the program's development, including the American Association of Thoracic Surgeons/Society of Thoracic Surgeons, the Society for Vascular Surgery, the American Association for Vascular Surgery, and the American College of Cardiology. The program will be aimed at improv-

ing quality of care and reducing medical error during the introduction of new procedures into practice and will respond to public and medical community concerns about whether practicing surgeons receive appropriate training to perform complex new procedures following their formal residencies. For more information, visit <http://www.amf-fame.org/news.html>.

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#S8 Solid 14K Gold	\$150	#S16A Dark Blue \$35			
<b>CHARM (Not Shown)</b>		#S16B Med. Lt. Blue \$35			
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## AWS issues call for grant applications

The Association of Women Surgeons (AWS) Foundation and Ethicon Endo-Surgery are accepting applications for a \$25,000 research grant for the year 2002.

Preference will be given to research topics in the following

two areas: minimal access approaches to treatment and/or diagnosis of cancer, bariatrics, and breast disease, as well as wound healing. Studies may be either clinical (human) or pre-clinical (animal/bench).

The grant will be awarded in

July 2001 for research to be conducted during the following 12 months.

The deadline for submission of grant applications is March 30, 2001. For more information and an application form, visit <http://www.womensurgeons.org>.

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## Surgical Research Clearinghouse available online

The Surgical Research Clearinghouse continues to be available online through the College's Web site ([www.facs.org](http://www.facs.org)). The clearinghouse is a listing of research scholarships, fellowships, and awards that are available

from various surgical specialty societies. The names of current recipients of some of the awards are included. The clearinghouse link is located near the bottom of the ACS home page.

Societies seeking to publicize

their scholarships may contact Jan Fair, Surgical Education and Research Dept., American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5354, e-mail [jfair@facs.org](mailto:jfair@facs.org).

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## CYBERSURGEON, from page 43

dicted. While virtual reality will not replace current hands-on teaching about new surgical procedures, it will give surgeons a chance to learn complex anatomy inside-out and gain extra practice before their first patient is scheduled. "It will give them the time to do an advanced procedure in a completely free environment," Dr. Silverstein says.

The technology also will test surgical skills. The UIC virtual surgery laboratory is exploring the possibility of developing reliable simulation models for evaluating whether surgeons perform the steps of a procedure in the right order and in an appropriate length of time. Models one day may include challenging clinical scenarios that test whether surgeons choose the right surgical approach to a problem or adapt to changing patient dynamics.

Pretreatment planning will take virtual reality

simulations to a different plane. "It will allow us to create a distributed, collaborative environment to look at and manipulate radiologic data. It will simulate standing at this spot, looking at this patient, right under these vessels and seeing what the anatomy looks like around there," Dr. Silverstein explains.

Virtual reality in the operating room will augment the limited visualization surgeons have with minimally invasive techniques by providing patient-derived data to surgeons by means of a pair of glasses that project anatomical images to a tiny triangular space in each lens. "This will have tremendous impact on the crowded operating room by bringing all those monitors and screens down to where they belong—in front of the surgeons' eyes—without blocking the rest of their view," Dr. Silverstein says. 

# The *Journal* page

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## Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

One of the rarest and most satisfying privileges an individual can experience is a long-term relationship with an icon. A personal association with Thomas Starzl, MD, FACS, extending over four decades, has enriched my life enormously. His article on "The Birth of Clinical Organ Transplantation," which will appear in the April issue of the *Journal of the American College of Surgeons*, is, in essence and appropriately, a personal narrative.

Before I met Dr. Starzl, I had been informed of his seminal contribution to the field of neuroanatomy. Shortly thereafter, I became aware of his unparalleled success in the field of renal transplantation. For those of us interested in hepatic resection, his championing of the significance of hepatotrophic factors was an important addendum. Obviously, he is best recognized for his un-

challenged leadership in the realm of transplantation of the liver. With persistence and energy that are unmatched, he took the field from conception, to embryonic phase, to infancy, and, ultimately, to routine.

But perhaps most importantly, Dr. Starzl accompanied his technical and pharmacologic initiatives with a well-articulated philosophy about the entire field of transplantation. He has served as both the pastor of an ever-expanding flock, and as an influential and evangelical theologian in the temple of transplantation.

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*Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.*

### INTRODUCTORY ABSTRACT from the April lead article

**The Birth of Clinical Organ Transplantation.** Thomas E. Starzl, MD, PhD, FACS. From the Thomas E. Starzl Transplantation Institute, University of Pittsburgh Medical Center, Pittsburgh, PA.

A consensus panel convened in March 1999 at UCLA to identify the principal milestones leading to the clinical applications of organ transplantation. The first turning point focused on acquired tolerance to allogeneic tissue. The animal tolerance models were the direct precursors of bone marrow transplantation.

The second turning point focused on organ tolerogenicity. Tolerance was effected by total body irradiation, pharmacologic immunosuppression, and adrenal cortical steroids. Using varying combinations of these modalities successful transplantation of kidney allografts resulted.

The liver was the next organ to be transplanted with success. Over the years the success rate was improved with the use of cyclosporine and tacrolimus. Successes were subsequently reported for heart, lung, pancreas, and small intestine. Bone marrow and organ transplantation are mirror image procedures that induce reciprocally modulating immune reactions: HVG and GVH. It is possible to spell out the meaning and mechanism of allogeneic tolerance. It may allow for the formulation of approaches to allotolerance induction and strategies for xenotransplantation.